Community Health Assessment

and

Community Health Improvement Plan

Monroe County, NY

2014-2017

November, 2013

For questions regarding this plan, please contact Anne Kern at 753-5332 or akern@monroecounty.gov

Table of Contents

Community Health Assessment

Community Health Improvement Plan: Prevent Chronic Disease

Community Health Assessment

Introduction

The NYS Prevention Agenda 2013-2017 is a blueprint for state and local action to improve the health of New Yorkers in five priority areas and to reduce disparities by race, ethnicity, disability and socioeconomic status. The five priority areas are:

- Prevent Chronic Diseases
- Promote a Healthy and Safe Environment
- Promote Healthy Women, Infants and Children
- Promote Mental Health and Prevent Substance Abuse
- Prevent HIV, Sexually Transmitted Diseases, Vaccine-Preventable Diseases and Healthcare-Associated Infections

As part of the NYS Prevention Agenda, local health departments are required to conduct a community health assessment and develop a community health improvement plan (CHIP) for at least two priority areas.

This document contains both a summary of the Community Health Assessment for Monroe County and the Community Health Improvement Plan (CHIP). The entire Community Health Assessment of the Monroe County Department of Public Health is comprised of this document, and the Health Report Cards that contain detailed information about the health status of mothers and children, adolescents and adults. All of these reports can be accessed online at www.healthaction.org.

Population

Monroe County is located in western New York, centered on the City of Rochester, with 19 suburban and rural towns. The population of Monroe County is 744,344, with 210,565 City residents.

The table to the left shows the population by age group and the percentage change between 2000 and 2010. The fastest growing group was adults ages 50-64 years old.

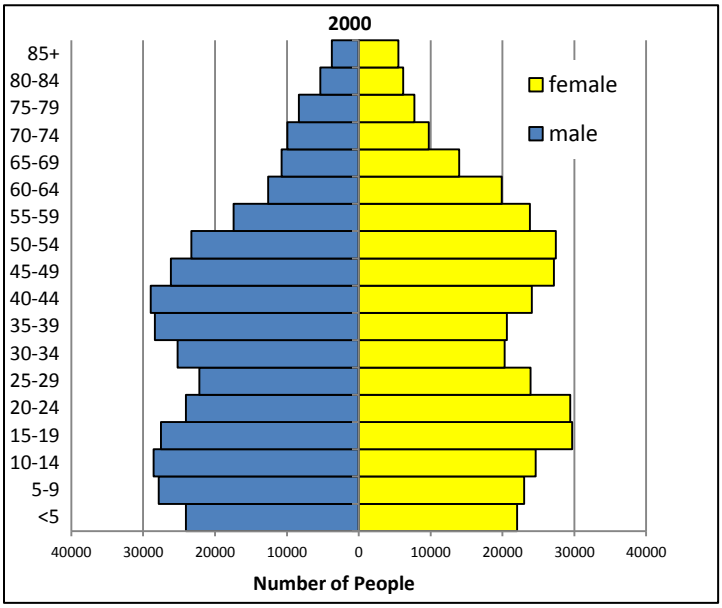
Population in Monroe County by Age Group, 2000 and 2010

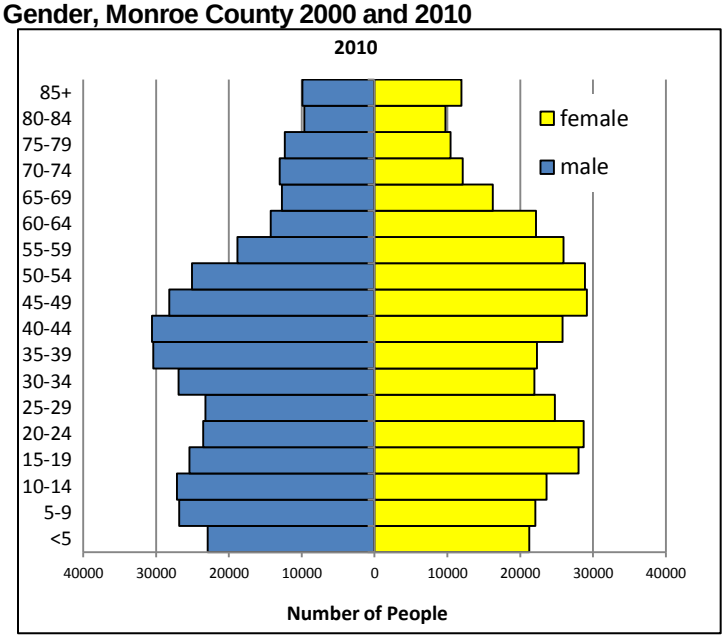
	2000	2010	% change
< 18	188,256	168,699	-10%
18-34	167,154	174,778	+3%
35-49	172,642	149,118	-14%
50-64	111,512	148,155	+33%
65-74	46,468	52,071	+12%
75-84	35,676	34,079	-4%
85+	13,635	17,444	+28%
total population	735,343	744,344	+1%

Source: 2000 and 2010 Decennial Census

The graphics on the next page show that between 2000 and 2010, the distribution by age has shifted towards an older population.

Population Distribution, By Age Group and Gender, Monroe County 2000 and 2010





Source: 2000 and 2010 Census

The table below shows the percent of the population by race and Latino origin in Monroe County, the city and suburbs.

Population by Race and Latino Origin Monroe County, 2010	Monroe County	City Total	Suburbs of Monroe
% White, Not Latino	73%	38%	87%
% African American/Black, Not Latino	14%	40%	5%
% Latino	7%	16%	4%
% Other races, multiple rates, Not Latino	6%	6%	5%

Source: Census 2010

Socioeconomic Indicators

Poverty and low educational levels are associated with higher rates of illness, premature death and fair or poor self-reported health status. Having limited financial resources has an impact on access to health care, and the ability to pay for medication and purchase healthy food. Literacy levels have a profound impact on an individual's ability to manage their health.

The median household income in Monroe County is $51,303, slightly below the national average ($51,914). In the city, the median household income is $30,540, far below the national average.

Fourteen percent (14%) of Monroe County residents live in poverty. The table to the right shows disparities in poverty status by residence and race/Latino origin.

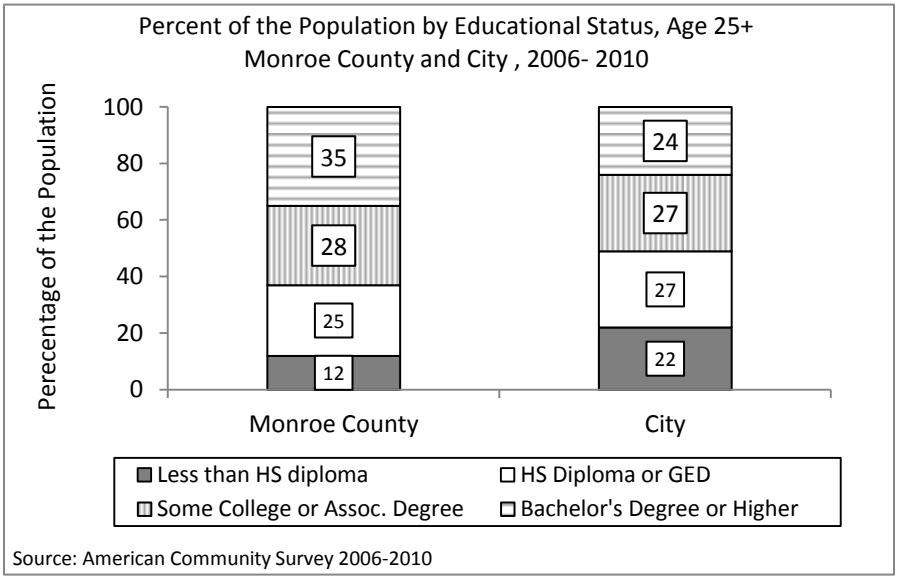
Poverty Status	Monroe County	City Total	Suburbs
% with income below poverty	14%	30%	7%
% White, Not Latino	8%	19%	6%
% African American/Black, Not Latino	32%	37%	14%
% Latino	33%	42%	17%

Source: American Community Survey, 2006-2010

Community Health Assessment

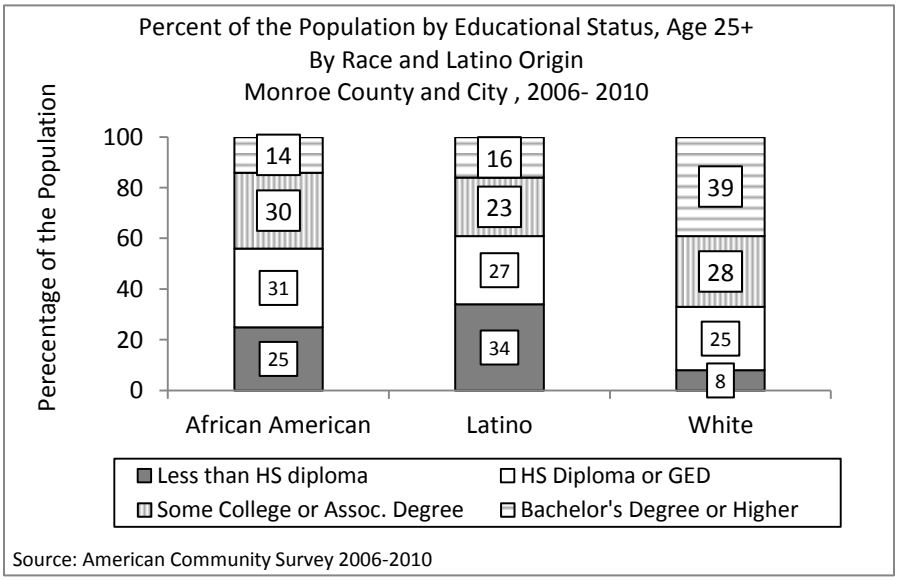
A low graduation rate in the City of Rochester is a major issue, with only 49% of 9th grade students graduating four years later.[1]

Twenty-two percent (22%) of city adults did not graduate from high school, compared to 12% county-wide.



Source: American Community Survey 2006-2010

A higher proportion of African American and Latino residents do not have a high school diploma.



Source: American Community Survey 2006-2010

Health Care System

Information in this section was provided by the Finger Lakes Health Systems Agency.

Hospitals in Monroe County consist of three "systems" – University of Rochester Medical Center, including Strong memorial Hospital and Highland Hospital; Rochester General Health System, including Rochester General Hospital; and Unity Health System, including Unity Hospital (former Park Ridge

[1] NYS Education Department, August 2011

Hospital) and the Genesee St campus (formerly St. Mary's Hospital). All three systems have associated nursing homes, health centers or clinics, and hospital-sponsored medical practices.

There are 2,722 active patient care physicians in Monroe County. Due to research, teaching and administrative duties, those physicians are the equivalent of 2,392 full-time patient care positions. The physician workforce has an average age of 51 years, but 35% are over age 55 and 13% are over age 65, leading to concerns about future supply of physician care. Approximately 32% of Monroe physicians are female. Only 4% of Monroe physicians are members of traditionally under-represented minority populations, raising issues of cultural sensitivity of the physician pool. [2]

Many local physicians, especially due to the presence of medical school and tertiary care hospital at the University of Rochester, are trained in all specialties and sub-specialties. Monroe physicians are trained in the following specialty groups as illustrated in the chart to the right.

Monroe County Physicians, 2009[1]

Specialty Group	FTEs	FTEs /100,000 pop.
Primary Care	764	105
Non-Primary Care	1,629	224
Ob/Gyn	140	19
IM Specialties	304	42
General Surgery	63	9
Surgical Specialties	272	37
Facility-Based	371	51
Psychiatrists	163	22
Total (All Physicians)	2,392	329

A national planning ideal is to have equal numbers of primary and non-primary care physicians, suggesting that Monroe may have an imbalance of supply.

The Monroe County supply of 329 FTE active patient care physicians per 100,000 population is above, but near the state average of 307, but well above the Upstate figure of 244/100,000.

The areas which include hospitals have the richest supply of physicians as shown in the chart to the right. Of concern, is the uneven distribution of physicians within the county.

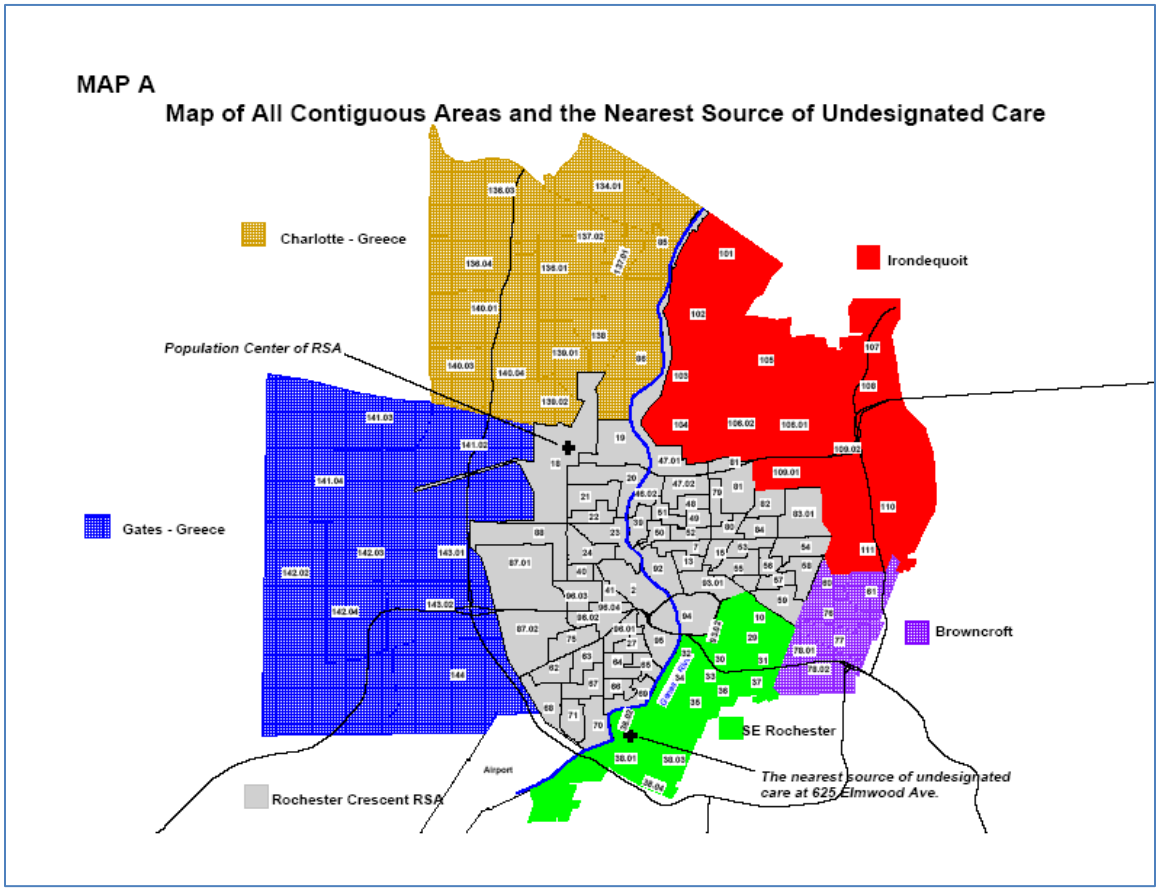
FTE Physicians per 100,000 Population, 2006

Region	Total	Primary Care*	Specialists
Brockport	114.6	64.6	49.9
Monroe-Northeast	76.7	53.4	23.3
Monroe-Northwest	271.6	109.4	162.2
Monroe-South	821.8	238.5	583.5
Monroe-Southeast	161.1	100.6	60.5
Monroe-Southwest	114.1	76.2	38.5
Rochester-Central South	68.0	68.0	0.0
Rochester-Central North	924.5	216.6	707.9
Rochester-Northwest	54.6	38.7	16.0
Rochester-Southeast	312.0	164.4	147.7
Rochester-West	121.9	76.5	45.2

[2]Per NYS Department of Education licensure data, as reported in *Annual New York State Physician Workforce Profile, 2010 Edition* published by the Center for Health Workforce Studies of the University of Albany. Demographic information was derived from a survey completed at time of licensure renewal during the period 2008 and 2009.

Community Health Assessment

Much of inner city Rochester is federally designated as a Primary Care Health Personnel Shortage Areas (HPSA). The map below illustrates the designated area in light grey. A similar area is also designated as a Dental HPSA.

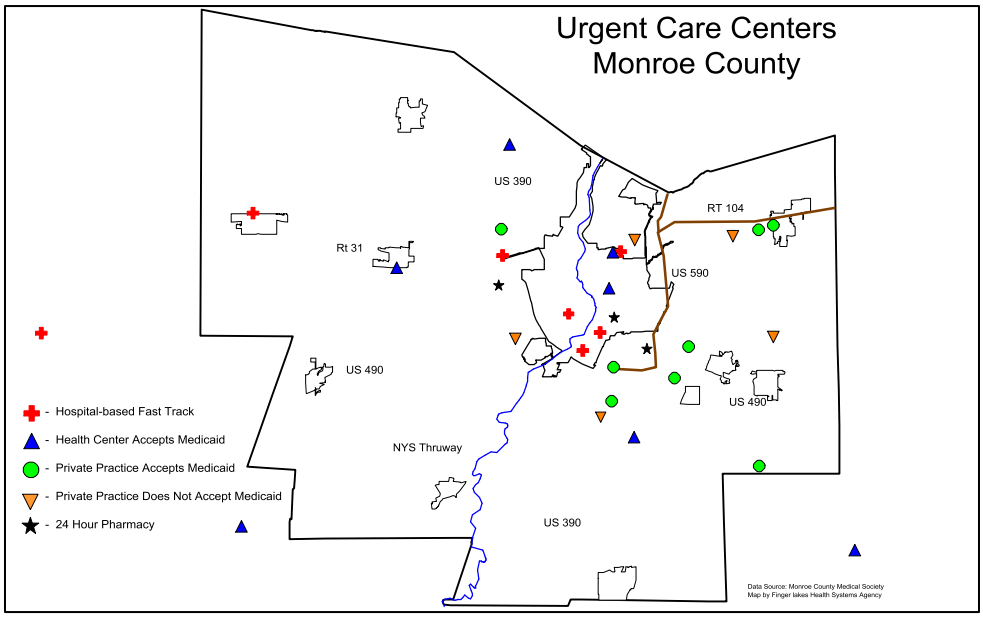


To assist in the provision of quality and accessible medical and health care services, Monroe long has been served by a network of federally-qualified Community Health Centers (FQHCs) – Jordan, (sites at Holland Street, Woodward and Brown Square) and Oak Orchard. Rochester Primary Care Network (now also an FQHC) has affiliated health centers that also provide health care within the inner city. These centers include Clinton Family Health Center, Genesee Health Center, Northeast Health Services, Orchard Street Community Health Center, and Unity Family Medicine Center.

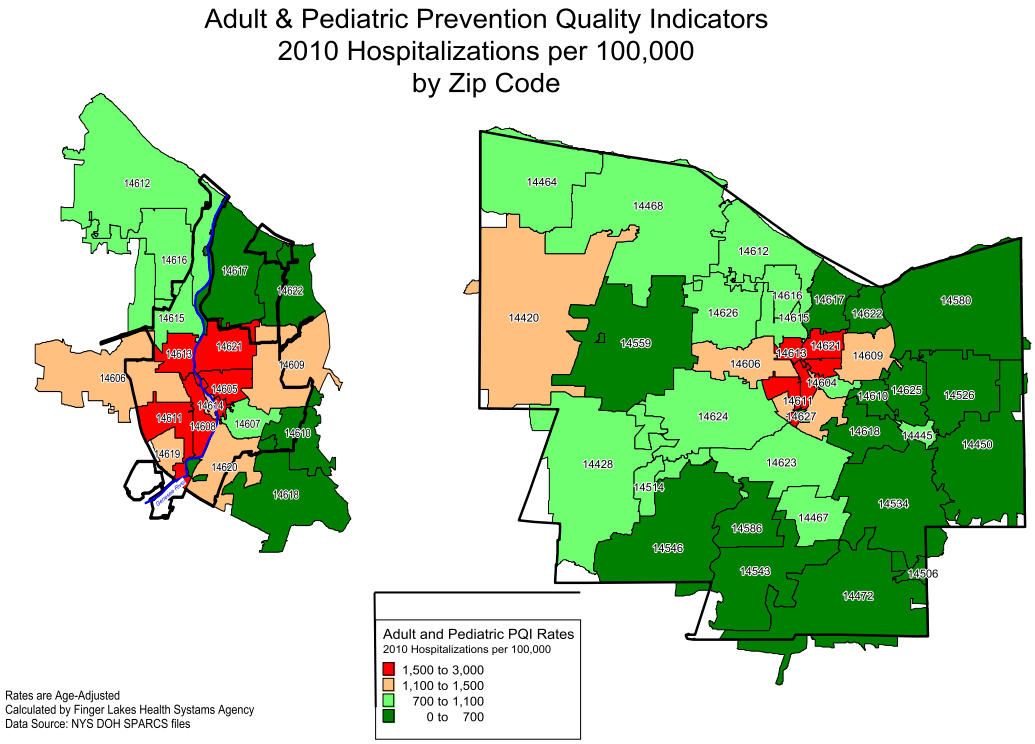
In addition, two free clinics serve primarily individuals who are uninsured – St. Joseph's Neighborhood Center and the Mercy Outreach Center.

For those in need of minor medical care not requiring an Emergency Department, there are also a number of "urgent care centers." Largest of these centers is the Walk-in Care Clinic operated by Unity Health System. This clinic, open 24 hours per day, provides over 10,000 visits annually in the emergency department facility of the former St. Mary's Hospital, now the Genesee Street campus of Unity. Each hospital also operates a "fast track" section of its Emergency Department. Lifetime Health operates after-hours services in three of its Health Centers. Other urgent care centers in the community are

operated as private physician offices and generally have evening and weekend hours. The map shows the location of existing urgent care centers.



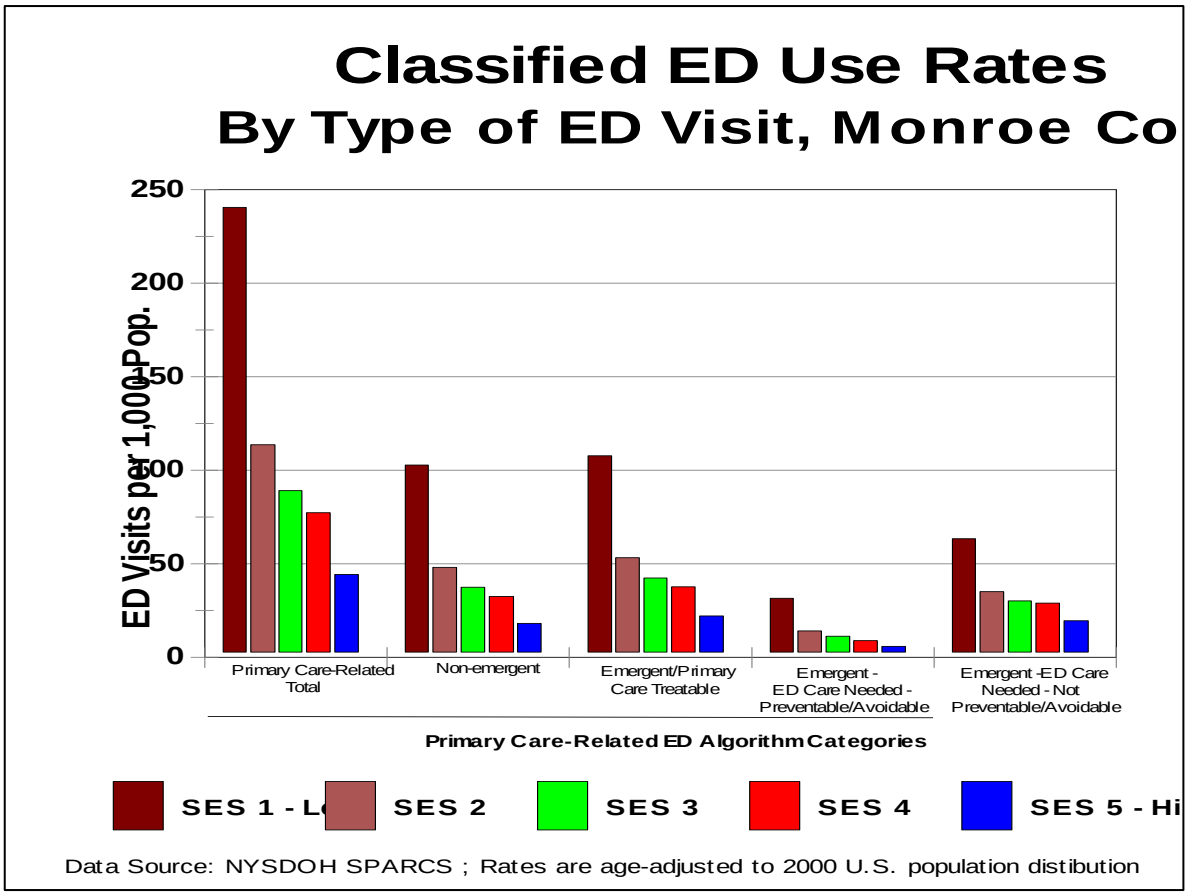
Although there are many physicians available in the county, and many resources such as the community health centers and urgent care centers, there are still indications that segments of the population do not receive needed primary care services. One such indicator is the number of persons hospitalized for medical conditions which, if adequate primary care had been received, the person may have not needed to be hospitalized. For example, if a person were cared for and trained to respond to problems with asthma, most would not require a hospital admission with asthma distress. Named by the federal Agency for Healthcare Research and Quality, such admissions are called Prevention Quality Indicators, or PQIs, and are measured as number of PQI admissions per 100,000 population. The PQI rates are not a reflection on the services of the hospitals – those presenting for care need the hospital care – but rather the lack of prevention and primary care which led to the medical crisis. The map on the next page shows PQI rates by geographic region.



Consistent with the geographic distribution of PQI admissions, there is a strong economic gradient in distribution of PQI. That is, areas with low socioeconomic status (SES) have substantially higher PQI rates than those with higher socioeconomic indicators: The PQI hospitalization rate for the lowest SES group is approximately three times that of the highest SES. PQI admissions are more prevalent among African American and Latino populations—about twice as prevalent compared to White populations--again reflective of differences in access to preventive and primary care services.

Application of the PQI classification system to Emergency Department (ED) visits suggests that many of those visits might be potentially avoidable. For many pediatric patients seeking ED care for asthma, for instance, primary care training of parents, and prophylactic use of medications, would often alleviate the need to seek ED care.

Similarly, New York University has developed an algorithm which classifies many ED visits on whether they were true "emergencies" or could have been cared for in a primary care setting. Overall, many ED visits which don't result in hospital admission are either primary care in nature or could have potentially been avoided with primary care. Local studies have shown that such ED visits are concentrated among the very young and very old, but also among African American and Latino populations. Data indicate such visits are not insurance driven, but are very sensitive to economic status. In Monroe, low-socio-economic status (SES) individuals tend to be concentrated within inner-city Rochester. In 2010, individuals living in the lowest SES (1) areas were over 5 times more likely to make a primary care-related ED visit than those from the highest SES (5) areas.



Most of the primary care practice owned by the three local health systems have either achieved or are working towards NCQA Certification of Patient Centered Medical Homes. In addition, Anthony Jordan Health Center has achieved certification. The Patient-Centered Medical Home (PCMH) model seeks to strengthen the physician-patient relationship by replacing episodic care based on illnesses and individual's complaints with coordinated care for acute, chronic, preventive, and end of life. Physician-led care teams are responsible for coordinating all of the individual's health care needs, and arranging for appropriate care with other qualified physicians and support services.

Community Health Assessment

Process for Conducting the Community Health Assessment/Data Sources

HEALTH *ACTION* is a community health improvement initiative that uses data and community input to select priority health goals, and develops interventions to address these goals. Health assessments by lifecycle groups, in the form of report cards, are developed by the Monroe County Department of Public Health under the direction of report card advisory committees. Members of these committees include representatives from health care systems and organizations, community-based organizations, schools, and public programs. These committees are tasked with reviewing data and providing input and insight on analysis and interpretation.

There are several sources of data used in the report cards. One primary source of local data is the Monroe County Adult Health Survey (AHS). This phone survey of adults aged 18 years and older is similar to the Behavior Risk Factor Survey administered nationally through the Centers for Disease Control and Prevention (CDC). The Adult Health Survey was first administered in 1997 and was repeated again in 2000, 2006, and most recently in the spring and summer of 2012. In the 2012 survey, 1800 responses were collected with half of the respondents from the City of Rochester. Oversampling was completed in zip codes with high proportions of residents with African American and Latino residents and those with limited income, in order to receive sufficient samples of these populations.

The Youth Risk Behavior Survey (YRBS) is a primary source of data for the Adolescent Health Report Card. The survey is a random sample survey of public high school students in Monroe County. It was last conducted in 2011.

Additional data include the following:

- Natality and mortality data: birth and death files
- Hospitalization data: Statewide Planning and Research Cooperative Systems (SPARCS) files
- Disease/ condition specific data: including cancer, AIDS/HIV and sexually transmitted diseases
- Program-based data: WIC Program, Childhood Lead Poisoning Prevention Program

After the publication of the report cards, a series of health forums are held to present the data and get input on priority health goals. These forums are set up by report card committee members. To ensure diverse input, forums are held throughout the community and participants include representatives from health care organizations, community-based organizations, residents, parents and adolescents. An example of the form used to get input during the forums is shown in the appendix. Based on the input received during these forums, priority health goals are selected. Below are a list of the current report cards and priorities for each lifecycle group.

Lifecycle Group	Report Card Date	Current Priorities
Mothers and Children	2011	-Increase Physical Activity and Improve Nutrition -Improve Social/Emotional Well Being
Adolescent	2012	-Reduce Teen Pregnancy -Improve Mental Health -Reduce Youth Violence/Bullying
Adult	2013	-Increase Physical Activity and Improve Nutrition -Improve Prevention and Management of Chronic Disease

Summary of Health Issues in Monroe County

As mentioned in the introduction to this report, detailed data about health status for mothers and children, adolescents and adults, can be found online in the report cards. This section provides a summary of health issues in Monroe County from the report cards.

Health Insurance Coverage/Access

Eight percent (8%) of adults age 18-64 years lack health insurance, which is better than the rate in NYS. Rates of uninsured however are nearly 3 times higher among City residents compared to Suburban residents and among African American and Latino residents compared to White residents.

Chronic Diseases

Cancer, heart disease and stroke are the leading causes of death in Monroe County, accounting for more than half of all deaths. The table on the below shows the leading causes of death, and both the average annual number of deaths and the % of all deaths attributed to the particular cause for all residents and adults by age group.

Leading Causes of Death
Monroe County, All Ages, and Adults Ages 20-64 and 65+, 2006-2010

ALL AGES			AGE 20-64			AGE 65+		
CAUSE	AVE ANNUAL # of DEATHS	% OF ALL DEATHS	CAUSE	AVE ANNUAL # of DEATHS	% OF ALL DEATHS	CAUSE	AVE ANNUAL # of DEATHS	% OF ALL DEATHS
CANCER	1503	24	CANCER	429	31	HEART	1268	26
HEART	1500	24	HEART	230	17	CANCER	1068	22
STROKE	335	5	UN. INJURY	98	7	STROKE	300	6
CLRD	258	4	SUICIDE	49	4	CLRD	230	5
UN. INJURY	202	3	HOMICIDE	37	3	ALZHEIMER'S	179	4
PNEUMONIA/FLU	184	3	STROKE	34	2	PNEUMONIA/FLU	167	3
ALZHEIMER'S	181	3	DIABETES	28	2	KIDNEY	112	2
KIDNEY	130	2	CLRD	28	2	UN. INJURY	89	2
DIABETES	108	2	LIVER DIS.	25	2	DIABETES	79	2
SEPTICEMIA	86	1	HIV/AIDS	22	2	SEPTICEMIA	69	1

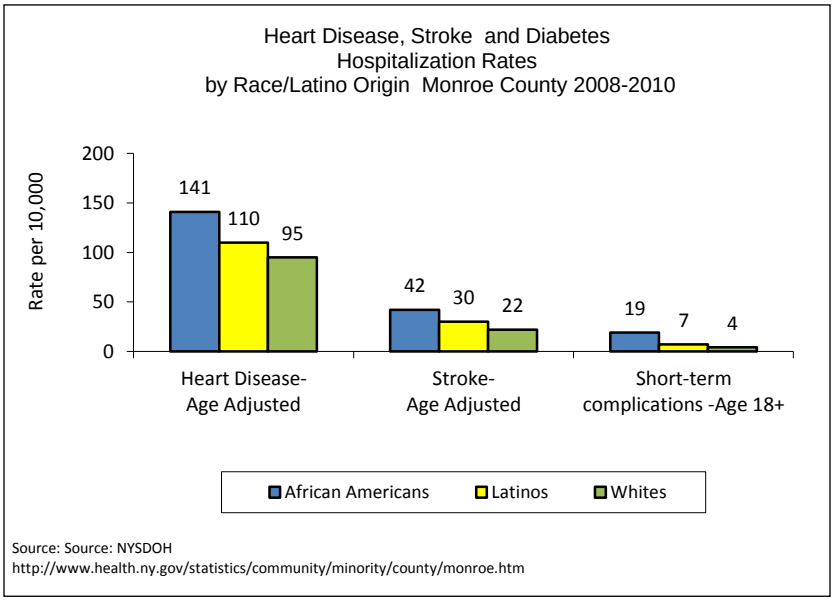
Source: Vital Records, MCDPH

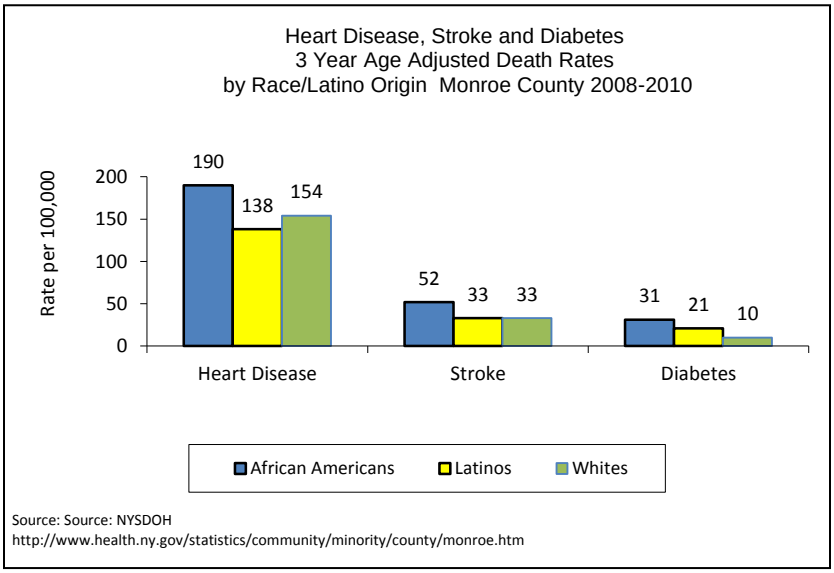
CLRD=chronic lower respiratory disease, KIDNEY=nephritis, nephrotic syndrome, nephrosis, UN. INJURY=unintentional injury

Cancer and heart disease are also the leading causes of premature death (average years of potential life lost before age 75 (YPLL)). County-wide, the average YPLL is 6.7 years. The average YPLL is two times higher in the city compared to the suburbs and more than 3 times higher among African American and Latino residents compared to White residents.

Hospitalization rates due to heart disease, diabetes and stroke in Monroe County are similar and in some cases lower than rates in NYS.

Within Monroe County however, there are significant disparities by race and Latino origin.





Two conditions that are risk factors for heart disease include diabetes and high blood pressure. Ten percent (10%) of Monroe County adults have diabetes, and 32% have high blood pressure. These rates are similar to NYS in 2012.[3]

Since the populations of city residents and of African Americans and Latinos have high proportions of adults under age 35, and the prevalence of these diseases/conditions increase with age, we calculated rates for these conditions for ages 35 and older by subpopulations. In this age category, there are some significant differences by residence and race/Latino origin as shown in the table on the next page.

[3] Source Monroe County Adult Health Survey, 2012 and NYS- Behavioral Risk Factor Survey, 2012

Ever Told by a Doctor or Health Professional that they have Diabetes or High Blood Pressure, Adults Ages 35+, 2012 (% of population)	City	Suburbs	African American	Latino	White
Diabetes	19*	12	24**	19**	12
High Blood Pressure	50*	39	64**	42	39

Source Monroe County Adult Health Survey, 2012
**Statistical significance p<0.05, City compared to Suburbs, ** Statistical significance p<0.05 African American and Latino compared to White*

Behavior risks for cancer, heart disease and stroke include excess body weight, lack of physical activity, poor nutrition and smoking. The table below shows the percentage of Monroe County residents with these risks and the disparities.

Risk Behaviors, Adults Ages 18+, 2012 (% of population)	Monroe County	City	Suburbs	African American	Latino	White
Obese	30	36*	27	38**	41**	27
No Physical Activity in the Past Month	16	25*	13	30**	26**	13
Consume 1+ Sodas/Sugar Sweetened Beverages per Day	23	30*	21	46**	23	20
Consume Fruit Less than 1 Time Per Day Past Month	28	33*	26	36**	42**	26
Consume Vegetables Less than 1 Time Per Day Past Month	20	30*	16	39**	31**	16
Currently Smoke	16	25*	13	23**	18	15

Source Monroe County Adult Health Survey, 2012
**Statistical significance p<0.05, City compared to Suburbs, ** Statistical significance p<0.05 African American and Latino compared to White*

The rate of obesity is higher in Monroe County compared to NYS (30% vs. 24%), and the rate of smoking is similar to New York State.

Cancer Screening

Mammography and colorectal cancer screening rates in Monroe County as a whole are similar to NYS. However, significant disparities exist in Monroe County by insurance status for those under age 65 as shown in the table below.

Cancer Screening, Adults Ages 18+, 2012 (% of population)	Uninsured	Insured
Had a mammogram in the past 2 years (women ages 40-64)	64*	84
Had a PAP test in the past 3 years (women ages 18-64)	65*	86
Had a colonoscopy in the past 10 yrs and/or a blood stool test in past yr (age 50-64)	64*	84

Source Monroe County Adult Health Survey, 2012
**Statistical significance p<0.05, uninsured compared to insured*

Sexually Transmitted Diseases (STDs) and HIV

STD rates in Monroe County are significantly higher than rates in NYS. Most STD cases occur among African American and Latino youth and young adults, who reside in the City. The incidence rate of HIV in Monroe County is lower than NYS. African American and Latino residents are disproportionately affected by HIV, with nearly three quarters of cases in Monroe County occurring among these two populations.

Maternal and Infant Health

According to state and local data, teen pregnancy rates in Monroe County are comparable to rates in NYS. While teen pregnancy rates have declined in both the county and city in recent years, rates in Rochester remain higher than rates in Buffalo and Syracuse. In Monroe County, rates among African Americans and Latinas are 5-6 times higher than rates among Whites.

Compared to rates in NYS, low birth weight, premature births and infant mortality are similar. Rate of unintended pregnancies are higher. Disparities by residence (city compared to suburbs) and by race and Latino origin exist in all of these measures.

Mental Health

The suicide rate in Monroe County is similar to NYS. Data from the adult health survey show that 11% of adults reported they felt calm and peaceful none or a little of the time in the past month and 5% felt downhearted or depressed all or most of the time. City residents were 1 ½ to 2 times more likely than Suburban residents, and Latino residents were 2-3 times more likely than White residents to report these mental health issues.

Homicides/Violence

The age adjusted homicide rate in Monroe County is higher than NYS. Nearly ¾ of homicide victims in Monroe County are African American or Latino residents. The assault hospitalization rate in Monroe County is lower than NYS. In Monroe County, compared to the rate among Whites, the assault hospitalization rate is nine time higher among African Americans and four times higher among Latinos.

Main Health Challenges in Our Community

After reviewing the health status and disease distribution in our community it is difficult to identify the "main health challenges" to address. Each health challenge presents several contributing causes.
If we look at the leading causes of death and years of potential life lost (YPLL) in Monroe County, cancer and heart disease account for nearly 50% of all deaths and more than 40% of years of potential life lost. McGinnis and Foege[4] summarized the role of health behaviors as a leading cause of death and labeled them the "actual causes of death". Based on these estimates, 33% of all deaths are attributed to tobacco, poor diet and physical inactivity. If we keep in mind that cancer and heart disease are mediated primarily by the behaviors of smoking, physical activity and healthy eating we could assume that affecting these behaviors should equate to our main health challenges.

We can also look at the data that the New York State Department of Health compiled in order to track progress on the New York State Prevention Agenda and identify areas where Monroe County is worse than NYS. (See appendix for full list) Of these 68 indicators, Monroe County fares worse than NYS in obesity, active transportation, access to grocery stores among those with low income, hospitalizations for complications of diabetes, sexually transmitted disease rates, and rates of teen pregnancy and unintended pregnancies. (see table on the next page)

[4] "Actual Causes of Death in the United States, 2000", JAMA, March 2004, 291 (10)

Monroe County Indicators For Tracking Public Health Priority Areas, 2013-2017 – NYS Prevention Agenda

Indicator	Data Years	Monroe County	New York State	NYS 2017 Objective
% of adults who are obese	2008-2009	31.3 (CI: 26.1-36.5)	23.2 (CI: 21.2-25.3)	23.2
% of commuters who use alternate modes of transportation	2007-2011	18.2	44.6	49.2
% of population with low-income and low access to a supermarket or large grocery store	2010	6.9	2.5	2.24
Rate of hospitalizations for short-term complications of diabetes per 10,000 - Ages 18+ years	2008-2010	6	5.6	4.86
Gonorrhea case rate per 100,000 women - Ages 15-44 years	2010	425.4	203.4	183.1
Gonorrhea case rate per 100,000 men - Ages 15-44 years	2010	360.1	221.7	199.5
Chlamydia case rate per 100,000 women - Ages 15-44 years	2010	2431.9	1619.8	1,458
Adolescent pregnancy rate per 1,000 females - Ages 15-17 years	2008-2010	32.8	31.1	25.6
% of unintended pregnancy among live births	2011	32.3	26.7	24.2
% of live births that occur within 24 months of a previous pregnancy	2008-2010	24.4	18	17

Source: www.health.ny.gov/prevention/prevention_agenda/2013-2017/indicators/2013/monroe.htm

One of the most significant health challenges in our community is health disparities. As noted in the summary, with nearly every major health indicator, there disparities by residence (city/suburb) and by race and Latino origin. Certain city neighborhoods in the northeast east, northwest and southwest bear the brunt of these health disparities. Significant social and environmental factors in these neighborhoods impact health, including high rates of poverty, school dropout rates and a high density of vacant housing and stores that sell unhealthy foods, cigarettes and liquor. In addition, there is a lack of stores that sell affordable healthy food. In these neighborhoods, crime and fear of crime have been identified as barriers to engaging in physical activity. Additional details about these disparities can be found in each of the report cards and the Finger Lakes Health System's Disparity Reports due to be published in the next few months.

Selecting Prevention Agenda Priorities

The Community Health Improvement Work Group (CHIW), comprised of representatives from all of the local health systems (Lakeside Health System, Rochester General Health System, Unity Health System, University of Rochester {Strong Memorial Hospital and Highland Hospital}) along with the Finger Lakes Health Systems Agency and the Monroe County Department of Public Health, was tasked with selecting the Prevention Agenda Priorities and developing the improvement plan.

The tables on the next page list the members of the team, along with the meeting dates.

Community Health Assessment

NAME	TITLE	AFFILIATION
Al Bradley	Senior Project Manager, High Blood Pressure Initiatives	Finger Lakes Health Systems Agency
Wade Norwood	Director of Community Engagement	Finger Lakes Health Systems Agency
Andrea DeMeo	Executive Director & COO – Center for Community Health	University of Rochester Medical Center
Theresa Green, MBA	Director of Community Health Policy & Education – Center for Community Health	University of Rochester Medical Center
Anne Kern	Public Health Program Coordinator	Monroe County Department of Public Health
Byron Kennedy, MD, PhD	Deputy Director	Monroe County Department of Public Health
Barbara Ficarra	Director of Public Relations	Highland Hospital
Shawn E. Fisher RN, MBA	Administrative Director of Nursing & Director of Surgical Services	Lakeside Health
Barbara McManus	Director, Marketing & Public Relations	Rochester General Health System
Kathy Parrinello	Associate VP and COO	Strong Memorial Hospital
Stewart Putnam	President, Health Care Services Division	Unity Health System
Wendy Wilts	Senior Vice President Clinical Service Lines	Unity Health System

Although the team meetings were not advertised to the public, anyone was welcome to attend. Information discussed at the meetings is shared with hospital leadership and to various community groups for input and comment as team members feel is appropriate.

Date	Time	Location
June 20, 2012	2:00 – 3:00	Center for Community Health
July 24, 2012	12:30 – 1:30	Center for Community Health
August 22, 2012	3:00 – 4:00	Center for Community Health
October 15, 2012	3:00 – 4:00	Center for Community Health
November 12, 2012	3:30 – 5:00	Center for Community Health
December 17, 2012	3:30 – 5:00	Center for Community Health
January 21, 2013	3:30 – 5:00	Center for Community Health
February 6, 2013	12:30 – 1:30	Center for Community Health
March 25, 2013	3:00 – 5:00	Center for Community Health
April 22, 2013	3:00 – 5:00	Center for Community Health
May 20, 2013	3:00 – 5:00	Center for Community Health
June 17, 2013	3:00 – 5:00	Center for Community Health
August 19, 2013	3:00 – 5:00	Center for Community Health
September 16, 2013	3:00 – 5:00	Center for Community Health
October 21, 2013	3:00 – 5:00	Center for Community Health

The process for selecting the priorities included a review of the **HEALTH *ACTION*** Report Cards/Community Health Assessment and the **HEALTH *ACTION*** priorities that have been selected based on community input (as noted on page 9). In addition, the team reviewed community assets and community programs that were already in place that could be built upon if they were selected as the

priorities. Consideration was also given to issues identified by the African American Health Coalition, the Latino Health Coalition, the Community Advisory Committee for University of Rochester, the Rochester Business Alliance, the Facing Race, Embracing Equity (FR EE) Health Disparities Work Group and the Advisory Committee for the Cancer Action Plan.

Based on the various sets of data, multiple community forums, current initiatives active and new, we established a list of health needs from which to focus, including:

- Decrease cigarette smoking among adults
- Decrease adult obesity
- Improve control of high blood pressure
- Decrease unintended pregnancy rates/teen pregnancy
- Decrease STDs/STIs, especially chlamydia and gonorrhea rates
- Improve mental health among adults and adolescents

Community Health Improvement Work Group members agreed that criteria were needed to prioritize the needs which should be addressed. Members agreed on a set of criteria to use to evaluate the health needs identified. The criteria were as follows:

CRITERIA	**SCORE/Comments**
IMPORTANCE (How important is this goal?) Number affected How much disability/illness this will prevent Long term impact on health	
LIKELIHOOD of IMPACTFUL SUCCESS What is the likelihood that setting this goal will result in substantial health improvements in 3-5 years?	
COMMUNITY SUPPORT Is there willingness on the part of community leaders, partner organizations, and residents to address this goal?	
HOSPITAL SUPPORT How likely are hospital leaders to strongly support this initiative and dedicate resources to its success?	
LEVEL of CURRENT COMPLEMENTARY ACTIVITY What is the level of community plans, activities and resources already directed to address similar goals?	
What is the potential to address health disparity?	
OVERALL RANK	

Community Health Assessment

The criteria as they relate to the identified health needs for Monroe County were discussed in an open forum among the team members. Each one of the prioritized needs was discussed.

Regarding issues of risky sexual behavior: Although data indicate that Monroe County is 'worse than' the state and has not reached the goals set in the NY State Prevention Agenda, this priority was not selected. Hospital leaders felt that although this issue certainly affects the members in the hospital's target areas, this is not a top priority for use of the hospitals' resources. Hospital leaders felt they were not the best entity to address this problem. There are community organizations who have this goal as their mission, and several initiatives that have just started in Monroe County that could be quite impactful.

Regarding issues of mental health: Although mental health is frequently a concern among the community, and the Community Health Improvement Work Group viewed it as important, this issue ranked lower in "likelihood of success" and "level of current complementary activity."

Regarding issues of chronic disease: Several community initiatives are underway to address this issue that could be enhanced and built upon. The Prevention Agenda indicators show significant room for improvement in the areas of chronic disease, and there are definitely areas of disparity that can and should be addressed.

The prioritization process identified "prevent chronic disease" as the priority area with three areas of focus:

- Reduce Obesity
- Reduce Illness, Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure.
- Increase Access to High-Quality Chronic Disease Preventive Care and Management in Clinical and Community Settings.

Assets and Resources

Assets and resources related to child and adolescent health can be found in the respective report cards at www.healthaction.org. Additional general assets are highlighted below. Assets related to the priority area "Prevent/Manage Chronic Disease" are described beginning on page 19.

General Assets

A major asset in Monroe County is its rich history of collaboration on addressing health issues. The three health systems, the University of Rochester Medical Center's Strong Memorial Hospital and Highland Hospital, Rochester General Health System, and Unity Health System have collaborated with the Finger Lakes Health System Agency and the Monroe County Department of Public Health for many years.

The Monroe County Department of Public Health (MCDPH) provides direct services designed to protect the public from health risks, disease and environmental hazards by providing preventive services, health

education, communicable disease prevention, enforcement of health codes and public health emergency planning. In addition, MCDPH has partnered with many organizations to implement the community health improvement initiative called **HEALTH *ACTION***, (described on pages 8 and 9).

The **Center for Community Health (CCH),** of the University of Rochester, was established in 2006 to support community-academic public health partnerships and to provide consultation to faculty, students and staff to establish community initiatives and research. Its mission is to join forces with the community to eliminate disparities and improve health through research, education and service.

The Finger Lakes Health Systems Agency (FLHSA) is the community-based health planning agency dedicated to promoting the health of the region's population. The organization provides a neutral community table for comprehensive planning among the health systems of the region. In addition, FLHSA is skilled in supporting and facilitating diverse coalitions. They have provided coordination and staff-support to the African American and Latino Health Coalitions and are the lead agency for HEALTHI Kids and for the Rochester Business Alliance High Blood Pressure Initiative.

Starting in late 2013, the Finger Lakes Health Systems Agency (FLHSA) will convene the **Regional Commission on Community Health Improvement** (RCCHI). Covering the 9 county Finger Lakes Region, the commission will be tasked with: developing community health improvement goals and measures related to the triple aim-(better health, better care and appropriate lower per capita cost of care) and identifying activities needed to attain the community goals. The commission will build upon knowledge that has been gained through experience with other FLHSA community initiatives. These lessons learned include: lack of integration between medical and non-medical determinants of health outcomes; lack of integration between mental health and physical care; lack of continuity/communication between providers and financial barriers to the "right care".

In July 2012, the Finger Lakes Health System Agency was awarded funding through the Centers for Medicaid and Medicare Innovations (CMMI) to support 65 primary care practices (many serving high risk populations) in moving towards a patient-centered, coordinated, and efficient model of care, and to integrate community services with primary care practices to address the social and behavioral determinants of health. The **CMMI grant** will fund 65 embedded care managers, 6 community health workers and 1 community based care coordinator.

The **African American and Latino Health Coalitions**, convened under the FLHSA umbrella, bring together community members, health professionals, and the FLHSA staff to define unmet needs, engage community members, develop new thought leaders, increase community knowledge, and develop standards and improve collection of data on patients' race, ethnicity, and preferred language. The coalitions publish periodic reports identifying pressing health issues and disparities confronting their respective communities. Current reports are due to be published in the next several months.

The business community, through the **Rochester Business Alliance's** (RBA) Health Planning Group and the Worksite Health Alliance of Greater Rochester, are increasingly engaged in addressing health in the

worksite and the community. The RBA has worked with the community on a variety of health issues including support for the local regional health care information organization, the application of Lean Six Sigma approaches to hospital management, physician compensation and the "eat well, live well" challenge, sponsored by Wegmans Food Markets.

Another community asset is the National Center for Deaf Health Research (NCDHR), a CDC-funded prevention research center. Initially funded in 2004, NCDHR's mission is health promotion and disease prevention with deaf and hard-of-hearing populations through community based participatory research.

The **Greater Rochester Health Foundation (GRHF)** is a major asset in the community, funding grants for health care delivery improvements and prevention projects. GRHF also funds neighborhood health status improvement projects that support grassroots efforts to improve the health of people living inneighborhoods with high rates of poverty and other factors that contribute to poor health status.

Assets/Initiatives Related to Prevention/Management of Chronic Disease

For the past several years the **Greater Rochester Health Foundation** (GRHF) has provided significant resources towards initiatives to address childhood obesity. A clinical quality improvement program for pediatricians to improve tracking of BMI and enhance skills for counseling about nutrition and physical activity was implemented. Several child care centers and schools have received funding to work towards policy, environmental and programmatic changes to increase physical activity and improve nutrition. A community campaign to promote healthy behaviors was also implemented.

Healthi KIDS, led by the Finger Lakes Health System Agency and funded by GRHF, the Robert Wood Johnson Foundation and the New York State Department of Health, is advocating for public policy and practice changes to increase physical activity and improve nutrition among children in Monroe County. The specific focus areas for policy changes are:

- Better school food
- Safer play areas
- Food standards at childhood centers
- At least 45 minutes of in-school physical activity
- Policies that support breastfeeding

In the past few years, the Rochester City School District (RCSD) has implemented policies to increase physical activity and improve nutrition. These include a policy requiring 20 minutes of recess per day in elementary schools and a policy restricting the sale of sugar sweetened beverages in vending machines in all district buildings. At the start of the 2013-2014, RCSD increased the number of minutes per week students attend physical education classes. In addition, RCSD is implementing comprehensive coordinated school health programs in each school. (funded by the HEART Grant described below).

Community Health Assessment

In 2011 the Center for Community Health of the University of Rochester Medical Center, the Monroe County Department of Public Health and numerous community partners were awarded a five-year, $3.6 million Community Transformation Grant (CTG) by the Centers for Disease Control and Prevention. The funding is being used to develop **HEART (Health Engagement and Action for Rochester's Transformation)**, a comprehensive initiative to improve the health of Monroe County residents by creating a community environment that supports healthy behaviors, thus preventing chronic disease and reducing health care costs. The core principles of CTG's are to maximize health through prevention, advance health equity and reduce health disparities.

Interventions funded by HEART include the following:

- Development and implementation of a Worksite Wellness Index to assistance employers with assessing their wellness programs and developing improvements
- Implementation of comprehensive coordinated school health programs in Rochester City School District schools and the Rochester School for the Deaf (as noted above)
- Implementation of an active transportation campaign
- Development and signage of designated walking routes in city neighborhoods
- Application of Crime Prevention Through Environmental Design and Safe Growth principles to places where people are or want to be physically active in order to reduce crime and fear of crime as a barrier to physical activity
- Development of a Food Hub to improve food access in city neighborhoods
- Recruitment and training of facilitators for the Diabetes Prevention Program

Significant progress has been made in recent years to support active transportation (biking, walking and transit). In 2011, the City of Rochester enacted a Complete Streets Policy and completed a Bike Master Plan. Since then, more than 40 miles street bicycle facilities have been installed, with many more planned. In the Suburbs, the towns of Brighton, and Penfield have completed some form of a bike/pedestrian plan. At least four towns/villages have received funding to complete plans and others are applying.

Initiatives to improve access to healthy food among those with limited income include: more than a dozen farmers markets that accept SNAP EBT cards; community gardens and community supported agriculture programs (CSAs).

The **Smoking and Health Action Coalition** (SHAC) of Monroe County is a Community Partnership funded by of the New York State Tobacco Control Program. The goals of the coalition are to: promote cessation from tobacco use; decrease the social acceptability of tobacco use; prevent the initiation of tobacco use among youth and young adults; eliminate exposure to secondhand smoke. Objectives include: 1. Decrease the number of retail stores that sell tobacco; 2. Increase the number of retail stores that have a written policy prohibiting the visibility/display of tobacco products; 3. Increase the number of local laws, regulations and voluntary policies that prohibit tobacco use in outdoor areas including public parks, beaches, play grounds, clubs, college campuses and outdoor areas of businesses, including

hospitals and other medical facilities, other grounds, recreation areas and in proximity to building entry ways; 4.Increase the percent of adult smokers and youth who live in households where smoking is prohibited.

The **Greater Rochester Area Tobacco Cessation Center (GRATCC)**, funded by the NYDOH Tobacco Control Program and housed at the University of Rochester, provides training and technical assistance to health care practitioners in the Rochester area. GRATCC uses evidence-based resources and programs to assists providers in the design and implementation of office-based systems that identify and effectively treat tobacco dependence based on the Department of Health and Human Services Clinical Practice Guidelines.

The Rochester Business Alliance and the Finger Lakes Health Systems Agency have developed the **High Blood Pressure Collaborative**, a group of more than 70 individuals from 40 organizations, working together to increase the percentage of people with high blood pressure who meet goal blood pressure measures through interventions in worksites, the community and the health care system. The long term goal is to decrease the incidence of heart attacks, heart failure, strokes, and kidney failure. Two interventions of the collaborative include:

- The formation of a registry of over 100,000 patients with high blood pressure to be used for monitoring of blood pressure control rates and for quality improvement within individual practices. More than 40 primary care practices owned by the hospital systems will enhance their current efforts to identify patients who have high blood pressure and to manage the disease more actively.
- Training of volunteer blood pressure ambassadors to provide accurate blood pressure checks and health advice at community events, health fairs, barbershops, places of worship and community centers.

The Diabetes Prevention Program is offered by the YMCA of Greater Rochester and the University of Rochester's Center for Community Health at various sites throughout the community.

The Cancer Services Program of Monroe County, housed at the University of Rochester's Center for Community Health and funded by the NYS Department of Health, is a partnership of over 40 community based agencies and 100 health care providers in Monroe County. The program provides breast, cervical and colorectal cancer screening free of charge to the uninsured, and if a diagnosis of breast, cervical or colorectal cancer is found, the program will help the client apply for Medicaid Cancer Treatment Program coverage. Case management is also available for those needing additional support and assistance as they go through diagnosis and treatment.

Community Health Improvement Plan: Prevent Chronic Disease

Introduction

This improvement plan for preventing chronic disease includes the three focus areas selected by the Community Health Improvement Work Group (CHIW):

- Reduce Obesity
- Reduce Illness, Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure.
- Increase Access to High-Quality Chronic Disease Preventive Care and Management in Clinical and Community Settings.

It incorporates work included in the Monroe County Joint Hospitals Community Services Plan, along with interventions planned or underway with numerous community partners.

Below is a key for abbreviations for partners included the plan.

ADA	American Diabetes Association
CHIW	Community Health Improvement Work Group, comprised of all three hospital systems, Finger Lakes Health Systems Agency, Monroe County Department of Public Health, University of Rochester - Center for Community Health
FLHSA	Finger Lakes Health Systems Agency
FOODLINK	FOODLINK
GRATCC	Greater Rochester Area Tobacco Cessation Center funded by the NYS Department of Health, housed at the University of Rochester
HBPC	High Blood Pressure Collaborative of the Rochester Business Alliance and FLHSA
HEART	Health Engagement and Action for Rochester's Health Grant – Main partners include the Monroe County Department of Public Health, University of Rochester - Center for Community Health
MCDPH	Monroe County Department of Public Health
MCMS	Monroe County Medical Society Quality Collaborative
RCCHI	Regional Commission on Community Health Improvement, housed at the FLHSA
SHAC	Smoking and Health Action Coalition of Monroe County- funded by the NYS Tobacco Control Program and housed at the American Lung Association – partners include the American Lung Association, American Heart Association, American Cancer Society, MCDPH, the Monroe County Medical Society, and the Smoking Research Program at the URMC.
UR-CCH	University of Rochester- Center for Community Health

Community Health Improvement Plan: Prevent Chronic Disease

Focus Area 1: Reduce Obesity

Defining the Problem:

Poor nutrition and lack of physical activity are the second leading causes of preventable deaths and are contributing factors to both cancer and heart disease, consistently the leading causes of death for Monroe County.

Fifteen percent of children age two and older are in the obese weight category and another 15% are in the overweight category. Rates are higher in the city (39%) compared to the suburbs (26%)[5].

According to the Monroe County Adult Health Survey (AHS), 30% of Monroe County adults are in the obese weight category and an additional 36% are in the overweight category. The rate of obesity in Monroe County is higher than the rate in NYS in 2012 (24%*), while the rates of overweight are not statistically different.

Rates of obesity are higher in the city compared to the suburbs, and among African American and Latino residents compared to White residents. Rates of overweight however are higher in the suburbs compared to the city and among Whites compared to Latinos. When the two categories are combined, the only statistically significant difference is between African Americans and Whites.

Obese/Overweight, Adults Ages 18+, 2012 (% of the population)	Monroe County	City	Suburbs	African American	Latino	White
Obese	30	36*	27	38**	41**	27
Overweight	36	31*	38	37	23**	38
Obese or Overweight	66	67	66	75**	65	64

**Statistical significance p<0.05, City compared to Suburbs,*

*** Statistical significance p<0.05 African American and Latino compared to White*

Source Monroe County Adult Health Survey, 2012

The basic behavioral causes of obesity are lack of physical activity and poor nutrition, both priority areas identified by community forums during the **HEALTH *ACTION*** process. The table on the next page shows the percentage of Monroe County adult residents with these risks and the disparities.

[5] ("Epidemiology Study of the Prevalence and Distribution of Obesity Among Monroe County Children and Adolescents, 2006", Departments of Pediatrics and Community and Preventive Medicine, University of Rochester Medical Center, with a Grant Supported by the Greater Rochester Health Foundation.

Community Health Improvement Plan: Prevent Chronic Disease

Focus Area 1: Reduce Obesity

Risk Behaviors, Adults Ages 18+, 2012 (% of the population)	Monroe County	City	Suburbs	African American	Latino	White
Engaged in Leisure-Time Physical Activity in the Past Month	84	75*	87	70**	74**	88
Consume 1+ Sodas/Sugar Sweetened Beverages per Day	23	30*	21	46**	23	20
Consume fruit less than one time per day	28	33*	26	36**	42**	26
Consume vegetables less than one time per day	20	30*	16	39**	31**	16

**Statistical significance p<0.05, City compared to Suburbs,*

*** Statistical significance p<0.05 African American and Latino compared to White*

Source Monroe County Adult Health Survey, 2012

The interventions included in this plan address some of the environmental, policy and social barriers to being physically active and eating a healthy diet. The plan focuses on four areas: 1. helping employers to make changes to ensure that employees have access to healthy choices, 2. developing a plan to support active transportation (biking and walking); 3. improving access to safe, inviting places to be physically active in city neighborhoods and 4. improving access to affordable healthy foods within city neighborhoods.

Overarching Objective - By December 2017, reduce the percentage of adults ages 18 years and older who are obese by 5% from 30% (in 2012) to below 28.5%. (Source: Monroe County AHS)

Indicators:

- By December 2017, increase the percentage of Monroe County adults who reported they walked, or bike to or from work school or to run errands one or more times in the past week by 10% from 26% (in 2012) to 29%. (Source: Monroe County AHS)
- By December 2017, increase the percentage of Monroe County adults ages 18 years and older who engage in leisure-time physical activity in the past month by 5% from 84% (in 2012) to 88%.(Source: Monroe County AHS)
- By December 2017, increase the percentage of City adults ages 18 years and older who engage in leisure-time physical activity in the past month by 5% from 75% (in 2012) to 79%.(Source: Monroe County AHS)
- By December 2017, decrease the percentage of City adults ages 18 years and older who do not consume fruit at least once per day by 5% from 33% (in 2012) to 31%. (Source: Monroe County AHS)
- By December 2017, decrease the percentage of City adults ages 18 years and older who do not consume vegetables at least once per day by 5% from 30% (in 2012) to 28%. (Source: Monroe County AHS)

Community Health Improvement Plan: Prevent Chronic Disease

Focus Area 1: Reduce Obesity

Goal 1.1. - Expand the role of public and private employers in obesity prevention.

Strategy 1.1.1. - Each of the hospital systems will utilize the locally developed Worksite Wellness Index as a tool to evaluate their wellness environment on an annual basis and then make evidence based improvements. The tool, accessible at <www.ihearteatwelllivewell.org/account>, was developed through the HEART Grant by the FLHSA Worksite Action Team of the High Blood Pressure Collaborative. It scores employers based how the worksite supports wellness in the areas of healthy eating, physical activity, breastfeeding, tobacco cessation, health education programs, behavioral health, health risk assessments, and organizational support of wellness.

The Community Health Improvement Work Team will meet quarterly to review results of the worksite index, share success stories in implementing action plans, and discuss how to overcome barriers.

Performance Measure1.1.1. - By September, 2016, expand the worksite wellness package at each hospital system by 3 effective interventions, as measured by increase in each hospital systems score on the community Worksite Wellness Index. (Source: Worksite Wellness Scores)

Activities	Target Date	Partners
Develop and release the Worksite Wellness Index	Complete	FLHSA/HEART
Collect Baseline data from CDC Environmental Scan	11/2013	Hospitals
Hospital Systems complete the Worksite Wellness Index	12/2013	Hospitals
Develop or identify a hospital based team to review index and plan for improvements	12/2013	Hospitals
Hospital Community Benefit Reporting Team Meeting	1/2014 then Quarterly	CHIW
Identify at least 3 improvement strategies recommended from the index for implementation	4/2014	Hospitals
Implementation of chosen strategies	4/2014-8/2016	Hospitals
Repeat Worksite Wellness Index	12/2014	Hospitals
Repeat Worksite Wellness Index	12/2015	Hospitals
Repeat Worksite Wellness Index	9/2016	Hospitals

Strategy 1.1.2. - Since the hospital systems are among the largest employers in the county, they will act as role models and examples for smaller businesses. Through partnership with the Rochester Business Alliance, hospital systems will assist smaller businesses in completing the Worksite Wellness Index and will share resources to help small businesses initiate healthy changes.

The Community Health Improvement Work Group will meet quarterly to review results of the worksite index, discuss progress on recruitment and mentoring.

Performance Measure- 1.1.2. - By December 2016, increase from 0 to 10 the number of small to medium worksites that complete the worksite wellness index and implement at least one improvement. (Source: Worksite Wellness Index)

Activities	Target Date	Partners
Develop and release the Worksite Wellness Index	Done	FLHSA/HEART
Community Health Improvement Work Group Meeting	1/2014 then Quarterly	CHIW
Assess baseline levels of completion of small/medium size business	1/2014	FLHSA, CHIW
Discuss strategies for assisting small/medium business with improved worksite wellness	1/2014	FLHSA, CHIW
Partner with the Rochester Business Alliance to identify small/medium sized worksites that are interested	2/2013	FLHSA
Collaborate with leaders at insurers to meet wellness staff consultants and coordinate intervention strategies	4/2014	FLHSA, CHIW
Develop a list of opportunities to promote the Worksite Wellness Index	4/2014	FLHSA, CHIW
Implement opportunities to promote the Worksite Wellness Index	4/2014-9/2016	FLHSA, CHIW
Develop a list of employee health champions for the hospital systems who are willing to serve as mentors	4/2014, ONGOING	HOSPITALS
Re-assess levels of completion of small and medium size business for adjustment to improvement strategy	Quarterly	FLHSA, CHIW

Goal 1.2.- Create community environments that promote and support physical activity.

Strategy 1.2.1. - Through the HEART Grant, neighborhood teams comprised of residents, police officers and representatives from city departments and community based organizations have begun applying principles of Crime Prevention through Environmental Design (CPTED) and Safegrowth to places where people are or want to be physically active. While CPTED looks at the physical design of a neighborhood (e.g. broken windows, areas littered with trash, and poor lighting), Safegrowth (also known as the 2nd generation of CPTED) takes into account other components that make a community safer and stronger such as neighborhood cohesion, culture and connectivity.

HEART Grant Partners regularly report data and progress on the work plan to the program manager and principle investigator. In addition, agreed upon data is reported to the HEART evaluation team and the Leadership Team on a quarterly basis. The Leadership Team, comprised of representatives from health care, community based organizations, the business community, the United Way, and a health foundation, provides input on the progress of the community action plan and makes recommendations for modifications based on lessons learned.

Performance Measure 1.2.1. - By September, 2016, increase from 0-35 the number of community venues in high risk neighborhoods in the City of Rochester where people are or could be physically active that have implemented CPTED/Safegrowth plans. Community venues include parks, recreation centers, trails, walking routes etc. (Source: HEART)

Activities	Target Date	Partners
Form teams and conduct CPTED/Safegrowth Training	Done	HEART, FLHSA, neighborhood teams(NT)
Develop plans that identify strategies	11/2013-3/2016	HEART, FLHSA,NT
Meetings to plan and advocate for implementation of strategies	1/2014-5/2016	HEART, FLHSA, NT
Implementation of strategies	2/2014-9/2016	HEART, FLHSA, NT

Strategy 1.2.2. - Also through the HEART Grant, the Center for Community Health (CCH) is working with high risk neighborhoods in the City of Rochester to identify, map and place signage on walking routes that are optimal for walking. In addition, CCH staff will assist with mobilizing residents to promote walking and use of the routes.

HEART Grant Partners regularly report data and progress on the work plan to the program manager and principle investigator. In addition, agreed upon data is reported to the HEART evaluation team and the Leadership Team on a quarterly basis. The Leadership Team, comprised of representatives from health care, community based organizations, the business community, the United Way, and a health foundation, provides input on the progress of the community action plan and makes recommendations for modifications based on lessons learned.

Performance Measure 1.2.2. - By September 29, 2016, increase from 8 to 16 the number of neighborhoods in the City of Rochester that have signed walking routes. (Source: HEART)

Activities	Target Date	Partners
Identify 8 neighborhoods that would like to develop walking routes	7/2013-3/2014	HEART, neighborhood groups (NG)
Take walking tours of neighborhoods to identify routes	9/2013-5/2014	HEART, neighborhood groups
Create maps of routes for walking maps and identify areas for signage	12/2013-5/2016	HEART, NG
Ensure placement of signage on routes	9/2016	HEART, NG
Monitor progress of walking groups through quarterly communications with community organizers, spotlight walking clubs that are achieving success in media.	On going-quarterly	HEART, NG

Strategy 1.2.3. - Through the HEART Grant, the Finger Lakes Health System Agency is implementing a community-wide campaign to promote active transportation. An active transportation coordinator at FLHSA is conducting an assessment of needs and gaps in active transportation which will be used to educate stakeholders, develop interventions and explore funding opportunities.

HEART Grant Partners regularly report data and progress on the work plan to the program manager and principle investigator. In addition, agreed upon data is reported to the HEART evaluation team and the Leadership Team on a quarterly basis. The Leadership Team, comprised of representatives from health care, community based organizations, the business community, the United Way, and a health foundation, provides input on the progress of the community action plan and makes recommendations for modifications based on lessons learned.

Performance Measure 1.2.3. - By September 2016, complete an assessment of gaps and opportunities to support active transportation in Monroe County along with recommendations about interventions for improvement and implement at least 3 recommendations to improve active transportation in Monroe County. (Source: HEART)

Activities	Target Date	Partners
Complete an assessment of gaps and opportunities to support active transportation in Monroe County	2/2014	FLHSA, HEART
Convene Active Transportation Committee(ATC)	3/2014	FLHSA, HEART
Review assessment and make recommendations	3/2014	FLSHA, HEART, ATC
Select priority recommendations	4/2014	ATC
Develop a work plan for implementing recommendations	5/2014	FLSHA, HEART, ATC
Implement recommendations	5/2014-9/2016	FLSHA, HEART, ATC

Goal 1.3 Improve access to affordable healthy foods in the City of Rochester in order to increase intake of fruits and vegetables.

Strategy 1.3.1 - Using their excess capacity and food related assets, along with funding from the HEART Grant, Foodlink has established a Food Hub. The Food Hub is utilizing Foodlink's existing network of agencies to distribute more fresh, local, and nutritious produce to underserved institutions. It also relies on programs like Farm Stands, Curbside Market, and a Healthy Corner Store Initiative to ensure that individuals living in low-income neighborhoods have an opportunity to purchase healthy and affordable foods. The plan is to increase the number of outlets for produce and explore strategies to increase nutrition education efforts associated with the farmstands and curbside markets.

Community Health Improvement Plan: Prevent Chronic Disease

Focus Area 1: Reduce Obesity

HEART Grant Partners regularly report data and progress on the work plan to the program manager and principle investigator. In addition, agreed upon data is reported to the HEART evaluation team and the Leadership Team on a quarterly basis. The Leadership Team, comprised of representatives from health care, community based organizations, the business community, the United Way, and a health foundation, provides input on the progress of the community action plan and makes recommendations for modifications based on lessons learned.

Performance Measure 1.3.1 - By September 29, 2016 increase by 10% the number of outlets for fruit and vegetables in the City of Rochester. (baseline and target to be determined) (Source: MCDPH, FOODLINK)

Activity	Target Date	Partners
Offer a mobile market service to Rochester Housing Authority and other community sites in Rochester	6/2013 - 10/2016	Foodlink, HEART
Convene a roundtable of patterns of food access and impact on health in Monroe County	10/2013	HEART, Foodlink
Recruit two corner stores to participate in Healthy Corner Store initiative	7/2013-9/2015	Foodlink, HEART
Provide technical assistance /funding to corner stores related to marketing healthy foods	1/2013-9/2016	Foodlink, HEART
Identify additional underserved neighborhoods for potential food outlet sites, including a map of outlets for healthy foods	3/2014-5/2016	MCDPH, HEART, Foodlink
Explore strategies to increase manpower for nutrition education efforts to coincide with Foodlink farmstands/curbside markets	3/2014	MCDPH, HEART, Foodlink

Focus Area 2: Reduce Illness, Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure

Defining the Problem:

Tobacco addiction is the leading preventable cause of morbidity and mortality in New York State (NYS) and in the United States[6]. Secondhand smoke is also a major health risk as it is a known cause of lung cancer, heart disease, low birth weight and other health problems.[7] The economic costs of tobacco are overwhelming and include both health care costs for smoking-related illnesses and lost productivity. Despite public education and policy to decrease tobacco use, there are still a substantial and troublesome amount of current smokers in Monroe County. Thirteen percent of public high school students smoke cigarettes (Monroe County, YRBS, 2011) and 16% of adults smoke, which equates to approximately 91,000. (Monroe County AHS, 2012)

There are significant disparities in those who smoke as shown in the table below.

Adults Ages 18+, 2012 (% of the population)	Monroe County	City	Suburbs	African American	Latino	White
Currently Smoke	16	25*	13	23**	18	15

**Statistical significance p<0.05, City compared to Suburbs,*

*** Statistical significance p<0.05 African American compared to White*

Source Monroe County Adult Health Survey, 2012

According to the Adult Health Survey, of smokers who visited their physician for a routine check-up in the past year, 82% said that their provider advised them to quit smoking. Despite national data showing that more than 70% of smokers want to quit[8], only half of smokers in Monroe County reported they tried to quit in the past year. In 2012, only 2500 Monroe County residents received counseling and/or nicotine replacement therapy from the NYS Quitline, a small proportion of the 91,000 who are estimated to smoke. Research shows that quit lines are an effective cessation intervention[9] and the reach of quit lines due to access and no/low caller cost means that they can have a huge public health impact.

Within high risk neighborhoods[10] in the City of Rochester, the density of stores with tobacco licenses is significant. These neighborhoods have less than one-quarter (24%) of the county's household population, but contain almost half (47%) of the establishments with tobacco licenses in the county. Several studies demonstrate product marketing within stores that sell tobacco influences smoking initiative among youth, provides cues to smoking, and stimulates purchasing among smokers trying to quit.[11,12,13,14]

[6] U.S. Department of Health and Human Services. *Reducing the health consequences of smoking: 25 years of progress. A report of the Surgeon General*. US Dept of Health and Human Services, Public Health Service. 1989.

[7] US Department of Health and Human Services (HHS). *The Health Consequences of Smoking. A Report of the Surgeon General*, 2004.

[8] 1 *Public Health Service Guidelines for Treating Tobacco Use and Dependence,* page 26, June, 2000.

[9] Representative sampling of evidence for quitline effectiveness can be accessed at http://globalqlnetwork.wordpress.com/about-quitlines/the-evidence-base/landmark-research/

[10] Include the following zipcodes - 14605,14606,14608,14609,14611,14613,14619,14621

[11] International Communications Research. National Telephone Survey of Teens Aged 12 to 17. 2007.

[12] National Cancer Institute. "The role of media in promoting and reducing tobacco use". NIH publication no. 07-6242 (2008)

[13] Wakefield, Germain, et al. "An experimental study of effects on schoolchildren of exposure to point-of-sale cigarette advertising and pack displays." Health Education Research Theory and Practice. 21(3):338-347 (2006)

[14] Lisa Henriksen, Nina C. Schleicher, Ellen C Feighery and Stephen P. Fortmann. *Pediatrics* published online July 19, 2010.

Community Health Improvement Plan: Prevent Chronic Disease

Focus Area 2: Reduce Illness, Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure

This plan focuses on three areas: improving linkages with the NYS Quitline to promote smoking cessation, developing a plan to promote policies to restrict tobacco marketing in stores and reducing exposure to second hand smoke.

Overall Objectives:

- By December 31, 2017, reduce the percentage of adults ages 18 years and older who currently smoke by 5% from 16% to below 15% among all adults. (Source: Monroe County AHS)
- By December 31, 2017, reduce the percentage of adults ages 18 years and older who live in the City and who currently smoke by 7% from 25% to 23% or less.(low SES) (Source: Monroe County AHS)

Indicators

- By December 31, 2016, increase the percentage of current smokers who made a quit attempt in the past year from by 10% from 51% to 53%. (Source: Monroe County AHS)
- By September, 2016, increase the number of unique individuals who receive treatment (counseling and/or NRT) from the NYS Smokers Quitline by 10% from baseline of 2500 in 2012 to 3000 in 2017. (Source: NYS Smokers Quitline)

Goal 2.1. - Promote tobacco use cessation, especially among low SES populations

Strategy 2.1. - Each hospital system, including the primary care practices in the CMMI initiative will develop and implement a smoking cessation policy which includes the NYS Quitline Opt-To-Quit Program. The Quitline offers confidential counseling and other cessation-related services to patients who use tobacco products**.** Through the *Opt to Quit* program, health providers can refer to the Quitline by linking directly through the EMR, directly entering the patients information online, or through fax. Patients will then receive a follow-up call from a *Quit-Coach* who will provide a stop smoking counseling session to tailor a cessation plan for the patient.

The Community Health Improvement Work Group will meet quarterly to review progress on this intervention, share success stories, and discuss how to overcome barriers.

Performance Objective 2.1.1. - By December 2016, increase from 0-6 the number of hospitals and primary care practices (including hospital based CMMI practices and/or FHQCs) that have a smoking cessation policy and which includes linkage to the NYS Quitline Opt-To-Quit Program.(Source: Community Health Improvement Work Group/GRATCC)

Community Health Improvement Plan: Prevent Chronic Disease

Focus Area 2: Reduce Illness, Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure

Activities	Target Date	Partners
Assess current policies/procedures related to assessing smoking status	2/2014	CHIW
Community Health Improvement Work Group meeting for updates	Beginning 2/2014 then Quarterly	CHIW
Review benchmark policy and process provided by Opt-to-Quit Program	2/2014-6/2014	CHIW
Identify committee or champion at each hospital for policy development and adoption	3/2014-6/2014	Hospitals
Develop and pass policy with Opt-to-Quit	5/2014-3/2015	CHIW, Hospitals, GRATCC
Work with NY Quit line and Opt-to-Quit logistics for implementation	7/2014-9/2016	Hospitals

Goal 2.2 Restrict tobacco marketing

Strategy 2.2. - The Smoking and Health Action Coalition of Monroe County, funded by the Tobacco Control Program of the New York State Department of Health, is developing a strategy to promote policy changes related to tobacco marketing. This strategy will involve educating the community about the influence of marketing on youth and mobilizing residents to advocate for changes.

SHAC will meet quarterly with the MCDPH to discuss progress on this strategy and brainstorm solutions to barriers.

Objective 2.2 By December 2017, increase from 0 to 1 the number of municipalities that have a policy restricting tobacco marketing. Policies could include one or more of the following: banning store displays, limiting the density of tobacco vendors and limiting their proximity to schools. (Source: Smoking and Health Action Coalition of Monroe County)

Activities	Target Date	Partners
Develop a plan for education and mobilization	7/2014	SHAC, MCDPH
Implement the plan	7/2014-10/2017	SHAC, MCDPH

Community Health Improvement Plan: Prevent Chronic Disease

Focus Area 2: Reduce Illness, Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure

Goal 2.3 Eliminate exposure to secondhand smoke

Strategy 2.3. - The Smoking and Health Action Coalition of Monroe County (SHAC), is working to reduce exposure to secondhand smoke in venues including multi-unit dwellings, parks, and playgrounds. SHAC will meet quarterly with the MCDPH to discuss progress on this strategy and brainstorm solutions to barriers.

Objective 2.3.1 By October 2013, increase from 0 to 2443 the number of Rochester Housing Authority (RHA) units with established prohibitive exposure to tobacco smoke practices reaching more than 4,370 people. (Source: Smoking and Health Action Coalition of Monroe County)

Objective 2.3.2 By December 31, 2017, increase from 2 to 4, the number of municipalities that implement smoke free policies in parks and/or playgrounds. (Source: Smoking and Health Action Coalition of Monroe County)

Activities	Target Date	Partners
Smoke free policy implementation- Rochester Housing Authority	Complete	SHAC, MCPH
Provide education/information about smoke free parks/playgrounds in various venues	8/2013-12/2015	SHAC, MCDPH
Assist municipalities with developing smoke free policies	12/2013-12/2017	SHAC, MCDPH

Community Health Improvement Plan: Prevent Chronic Disease

Focus Area 3: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings

Defining the Problem:

Chronic diseases are the leading causes of death in Monroe County. Heart disease, cancer, stroke and diabetes combined account for more than ½ of all deaths.

Hospitalization rates due to heart disease, diabetes and stroke in Monroe County are similar and in some cases lower than rates in NYS. Within Monroe County however, there are significant disparities by race and Latino origin.

Ten percent of Monroe County adults have diabetes, and 32% have high blood pressure. Since the populations of city residents and of African Americans and Latinos have high proportions of adults under age 35, and the prevalence of these diseases/conditions increase with age, we calculated rates by subpopulation for ages 35 and older. In this age category, there are significant differences by residence and race/Latino origin as shown in the table below.

Ever Told by a Doctor or Health Professional that they have Diabetes or High Blood Pressure, Adults Ages 35+, 2012	City	Suburbs	African American	Latino	White
Diabetes	19*	12	24**	19**	12
High Blood Pressure	50*	39	64**	42*	39

**Statistical significance p<0.05, City compared to Suburbs,*

*** Statistical significance p<0.05 African American compared to White*

Source Monroe County Adult Health Survey, 2012

In NYS an estimated 25% of adults have pre-diabetes.[15] Those with pre-diabetes are five to 15 times more likely to develop Type 2 diabetes than those without the condition. People with pre-diabetes are also at increased risk for cardiovascular disease.[16]

Preventing and managing chronic disease requires both evidence based clinical care and linkages to community programs. Guidance from health care providers is important to helping people make healthy choices to prevent and manage disease. Health care providers however face challenges to provide the intensive assistance often needed to address the social and behavioral determinants of health and help empower patients to engage in healthy behaviors. These barriers include lack of time and reimbursement, along with knowledge of community programs and services. Community programs can help address this need.

[15] Adapted from Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report Series. Self-reported pre-diabetes and risk-reduction activities--United States, 2006. 2008; 57(44):1203-1205 AND Cowie CC, Rust KF, Fored ES, Eberhardt MS, Dyrd-Holt DD, Li C, Williams DE, Gregg EW, Bainbridge KE, Saydah SH, Geiss LS. Full accounting of diabetes and pre-diabetes in the US population in 1988-1994 and 2005-2006. *Diabetes Care*. February 2009; 32(2):287-294.

[16] Cited in Centers for Disease Control and Prevention, Diabetes Public Health Resources. Frequently Asked Questions about Pre-Diabetes. Available at http://www.cdc.gov/diabetes/faq/pre-diabetes.htm. Accessed June 1, 2009.

Community Health Improvement Plan: Prevent Chronic Disease

Focus Area 3: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings

This plan focuses on three areas: developing a centrally located resource base of community based programs with linkages to health care providers, expansion of the High Blood Pressure Collaborative Registry, and the development and dissemination of evidenced based guidelines for diabetes/pre-diabetes.

Overall Objectives:

- By December 31, 2017, reduce the age-adjusted hospitalization rate for heart attack by 10% from 14.6 per 10,000 residents (in 2010) to 13 per 10,000 residents of all ages. (Source: SPARCS)
- By December 31, 2017, reduce the rate of hospitalizations for short-term diabetes complications among adults age 18+ by 5% from 6.2 per 10,000 (2009-2011) to 5.9 per 10,000 (Source SPARCS)

Indicators

- By December 31, 2017, increase the percentage of adults ages 18+ years with hypertension who have controlled their blood pressure (below 140/90) from 66.7% (in 2012) for residents in the blood pressure registry to 79%. (Source: High Blood Pressure Collaborative Registry)
- By December of 2017 increase the proportion of adults who have been diagnosed with pre-diabetes by 10% from base-line in 2013. (baseline to be determined in 2014 based on EBRFSS)

Goal 3.1.1. - Improve Clinical Community Linkages.

Strategy 3.1.1- This strategy involves developing a centrally located resource base of community based programs that is linked to primary care practices.

All of the partners will collaborate on this initiative and the Community Health Improvement Work Group will meet quarterly to discuss progress and change course if needed.

Performance Objective 3.1.1. - By December 31, 2016 develop a central repository for community based resources that is sustainable and user-friendly and link the repository to health care providers, including care managers and community health workers.

Community Health Improvement Plan: Prevent Chronic Disease

Focus Area 3: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings

Activities	Target Date	Partners
Establish an advisory group (AG) comprised of representatives from health care and community based organizations providing support services	4/2014	CHIW, FLHSA, MCDPH, RCCHI
Discuss goals and objectives for community linkages and establish an assessment plan of the current system	5/2014	CHIW, FLHSA, MCDPH, RCCHI, AG
Explore community resource information systems and identify gaps in information and barriers to providers accessing the information	5/2014-11/2014	CHIW, FLHSA, MCDPH, RCCHI, AG
Compile an inventory of community health support programs, resource guides, online databases	5/2014-12/2014	CHIW, FLHSA, MCDPH, RCCHI, AG
Vet findings in the community	1/2015	CHIW, FLHSA, MCDPH, RCCHI, AG
Develop an action plan for user-friendly access to an updated and accurate inventory	2/2015-4/2015	CHIW, FLHSA, MCDPH, RCCHI, AG
Implement the action plan to establish easy and effective linkage points	5/2015-12/2016	CHIW, FLHSA, MCDPH, RCCHI, AG

Goal 3.1.2. - Improve Evidence Based Care

Strategy 3.1.2. - The High Blood Pressure Collaborative was created by the Rochester Business Alliance Health Care Planning Team in partnership with the Finger Lakes Health Systems Agency and over 60 organizations to improve control of blood pressure. A de-identified population registry of 103,000 patients (June 2013) with high blood pressure that includes practices associated with all three hospital systems, along with all of the Federally Qualified Health Centers, Lifetime Health Medical Group and four private practices has been created. In six month intervals, registry data is used to generate community-wide performance reports as well as practice specific reports. Variables measured and reported include high blood pressure control rates and rates for patients not seen in the past 13 months. Data is also reported in drill downs by gender, race/ethnicity, socio-economic status and age group. Practice reports include suggestions for performance improvement.

Practices then utilize registry data to inform quality improvement initiatives to identify patients who have uncontrolled high blood pressure and to manage the disease more actively. Trained practice improvement consultants use registry data to identify practices that have good control rates in order to identify best practice strategies and this is in turn shared with other practices.

The High Blood Pressure Collaborative Best Practice Work Group meets every other month and monitors data collection and analysis of the registry data and makes recommendations for changes and improvements.

Performance Measure 3.1.2. - By December 2016 increase the number of practices submitting data to the registry from 82 (2012) to 90 and the number of records in the registry from 103,000 to 125,000. (Source: FLHSA)

Activities	Target Date	Partners
Recruit practices to participate in the registry	Ongoing	HBPC, MCMS, Private Practices
Create community-wide registry reports and disseminate to participating practices	Every 6 months	HBPC
Provide consultation with practices related to improving blood pressure control	On going	HBPC, Hospitals

Strategy 3.1.3. - This strategy involves the development and dissemination of community-wide physician guidelines for diabetes and pre-diabetes, along with educational programing for health care providers about the management of diabetes and pre-diabetes.

The Quality Collaborative Council of the Monroe County Medical Society is planning to develop and disseminate two community-wide physician guidelines: 1. Adult diabetes care and 2. Screening for and management of pre-diabetes. The guidelines will include information on how to enroll and refer patients to educational resources and programs including The Living With Type 2 Diabetes program, and the Diabetes Prevention Program. A resource list of diabetes management and DPP programs will be developed and maintained, so that physicians can refer patients to these programs.

Community Health Improvement Plan: Prevent Chronic Disease

Focus Area 3: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings

The American Diabetes Association (ADA) is planning to offer both in- person and online training with CMEs to health care providers about the prevention and management of diabetes.

The Quality Council meets monthly to discuss guideline development and dissemination. The Director of the Monroe County Department of Public Health serves on the Council. The Monroe County Department of Public Health will work with the American Diabetes Association to ensure development of information and resources to include in the guidelines.

Performance Measure 3.1.3a. - Increase provider enrollment in the American Diabetes Association's Living with Type 2 Diabetes Program 20%. (Source: American Diabetes Association)

Performance Measure 3.1.3b. - Increase enrollment in the Diabetes Prevention Program by 10% from baseline in 2013. (Source: Baseline to be determined by MCDPH)

Performance Measure 3.1.3c. - By December 2017, 200 health care providers will receive CMEs for diabetes prevention and management. (Source: American Diabetes Association)

Activities	Target Date	Partners
Adopt adult diabetes care guidelines	3/2014	MCMS
Disseminate adult diabetes care guidelines	4/2014-6/2014	MCMS, ADA
Form committee and develop pre-diabetes guidelines	2/2014-9/2014	MCMS
Develop resource list of diabetes management programs and diabetes prevention programs	6/2014-7/2014	MCDPH, ADA
Adopt pre-diabetes care guidelines	9/2014	MCMS
Disseminate pre-diabetes guidelines	10/2014-12/2014	MCMS, ADA
Plan for educational CME programs	4/2014-11/2014	ADA
Host provider education programs for diabetes prevention and management (both live and online)	11/2014-12/2017	ADA

APPENDIX A

HEALTH ACTION
Priorities for Monroe County

GOAL SELECTION WORKSHEET

Adolescents, 2012

Directions: Rate the goals in the boxes across the top against the listed criteria by working down each column.

The higher the total score, the more likely it is that the goal is a priority for action over the next few years.

HEALTH GOALS	Importance 1---2----3----4----5 Little Great	Likelihood that things can change 1----2----3----4----5 Little Great	Total
Reduce Sexual Risk Behaviors			
Reduce Violence and Bullying			
Improve Mental Health			
Reduce Use of Alcohol and Other Drugs			
Reduce Use of Tobacco			
Build Youth Assets			
Increase Physical Activity/Exercise and Improve Eating			
Decrease Accidental Injuries			
Help Youth Get Preventive Health Care			

Which goal do you think should be the community wide priority for action and why?

Importance:
How important do you think this goal is for adolescents? (Think about how many teens are affected by this goal and how this issue affects teens in the long-term)

Likelihood that things can change:
What is the likelihood that addressing this goal in our community can result in improvement over the next 4-5 years?

PREVENTION AGENDA FOCUS AREAS AND MEASURES				
Improve Health Status and Reduce Health Disparities				
Indicator	**Data Years**	**Monroe County**	**New York State**	**NYS 2017 Objective**
% of premature death (before age 65 years)[1]	(2008-2010)	21.9	24.3	21.8
Ratio of Black non-Hispanics to White non-Hispanics[2]		2.96	2.12	1.87
Ratio of Hispanics to White non-Hispanics[3]		3.08	2.14	1.86
Age-adjusted preventable hospitalizations rate per 10,000 - Ages 18+ years[4]	(2008-2010)	129.4	155	133.3
Ratio of Black non-Hispanics to White non-Hispanics[5]		2.6	2.09	1.85
Ratio of Hispanics to White non-Hispanics[6]		1.88	1.47	1.38
% of adults with health insurance - Ages 18-64 years[7]	2010	87.8 (86.9-88.7)	83.1 (82.9-83.3)	100
Age-adjusted % of adults who have a regular health care provider - Ages 18+ years[8]	(2008-2009)	90.9 (86.4-95.4)	83.0 (80.4-85.5)	90.8
Promote a Healthy and Safe Environment				
Indicator	**Data Years**	**Monroe County**	**New York State**	**NYS 2017 Objective**
Rate of hospitalizations due to falls per 10,000 - Ages 65+ years[9] age 65-74 age 75-84 age 85+	(2008-2010)	 69.9 223.8 580.8	 77.5 230.8 567.7	Maintain
Rate of emergency department visits due to falls per 10,000 - Ages 1-4 years[10]	(2008-2010)	399.7	476.8	429.1
Assault-related hospitalization rate per 10,000[11]	(2008-2010)	3.9	4.8	4.3
Ratio of Black non-Hispanics to White non-Hispanics[12]		9.11	7.43	6.69
Ratio of Hispanics to White non-Hispanics[13]		4.42	3.06	2.75
Ratio of low income ZIP codes to non-low income ZIP codes[14]		8.92	3.25	2.92
Rate of occupational injuries treated in ED per 10,000 adolescents - Ages 15-19 years[15]	(2008-2010)	36.9	36.7	33
% of population that lives in a jurisdiction that adopted the Climate Smart Communities pledge[16]	(2012)	35.2	26.7	32
% of commuters who use alternate modes of transportation[17]	(2007-2011)	18.2	44.6	49.2
% of population with low-income and low access to a supermarket or large grocery store[18]	(2010)	6.9	2.5	2.24
% of homes in Healthy Neighborhood Program that have fewer asthma triggers during the home revisits[19]	(2008-2011)	17.4	12.9	20
% of residents served by community water systems with optimally fluoridated water[20]	(2012)	100	71.4	78.5

Prevent Chronic Disease				
Indicator	**Data Years**	**Monroe County**	**New York State**	**NYS 2017 Objective**
% of adults who are obese[21]	(2008-2009)	31.3 (26.1-36.5)	23.2 (21.2-25.3)	23.2
% of children and adolescents who are obese[22]	(2010-2012)	17.6	17.6	NYC: 19.7 ROS: 16.7
% of cigarette smoking among adults[23]	(2008-2009)	19.1 (14.6-23.7)	16.8 (15.1-18.6)	15
% of adults (ages 50-75) who receive a colorectal cancer screening based on the most recent guidelines [24]	(2008-2009)	72.4 (66.8-77.4)	66.3 (63.5-69.1)	71.4
Asthma emergency department visit rate per 10,000[25]	(2008-2010)	59.1	83.7	75.1
Asthma emergency department visit rate per 10,000 - Ages 0-4 years[26]	(2008-2010)	180.1	221.4	196.5
Age-adjusted heart attack hospitalization rate per 10,000[27]	(2010)	14.6	15.5	14
Rate of hospitalizations for short-term complications of diabetes per 10,000 - Ages 6-17 years[28]	2008-2010	3.9	3.2	3.06
Rate of hospitalizations for short-term complications of diabetes per 10,000 - Ages 18+ years[29]	2008-2010	6	5.6	4.86
Prevent HIV/STDs, Vaccine Preventable Diseases and Healthcare-Associated Infections				
Indicator	**Data Years**	**Monroe County**	**New York State**	**NYS 2017 Objective**
% of children with 4:3:1:3:3:1:4 immunization series - Ages 19-35 months[30]	(2011)	51	47.6	80
% of adolescent females with 3-dose HPV immunization - Ages 13-17 years[31]	(2011)	40.4	26	50
Age-adjusted % of adults with flu immunization - Ages 65+ years[32]	(2008-2009)	84.6 (79.1-90.1)	75.0 (71.5-78.5)	66.2
Newly diagnosed HIV case rate per 100,000[33]	(2008-2010)	11.5	21.6	14.7
Difference in rates (Black and White) of new HIV diagnoses[34]		38	59.4	45.7
Difference in rates (Hispanic and White) of new HIV diagnoses[35]		22.4	31.1	22.3
Gonorrhea case rate per 100,000 women - Ages 15-44 years[36]	(2010)	425.4	203.4	183.1
Gonorrhea case rate per 100,000 men - Ages 15-44 years[37]	(2010)	360.1	221.7	199.5
Chlamydia case rate per 100,000 women - Ages 15-44 years[38]	(2010)	2431.9	1619.8	1,458
Primary and secondary syphilis case rate per 100,000 males[39]	(2010)	3.6	11.2	10.1
Primary and secondary syphilis case rate per 100,000 females[40]	(2010)	0.8†	0.5	0.4

APPENDIX B

Indicator	Data Years	Monroe County	New York State	NYS 2017 Objective
% of preterm births[41]	(2008-2010)	10.3	12	10.2
Ratio of Black non-Hispanics to White non-Hispanics[42]		1.65	1.61	1.42
Ratio of Hispanics to White non-Hispanics[43]		1.31	1.25	1.12
Ratio of Medicaid births to non-Medicaid births[44]		1.33	1.1	1
% of infants exclusively breastfed in the hospital[45]	(2008-2010)	61.7	42.5	48.1
Ratio of Black non-Hispanics to White non-Hispanics[46]		0.51	0.5	0.57
Ratio of Hispanics to White non-Hispanics[47]		0.68	0.55	0.64
Ratio of Medicaid births to non-Medicaid births[48]		0.55	0.57	0.66
Maternal mortality rate per 100,000 births[49]	(2008-2010)	19.4†	23.3	21
% of children who have had the recommended number of well child visits in government sponsored insurance programs[50]	(2011)	67.7	69.9	76.9
% of children ages 0-15 months who have had the recommended number of well child visits in government sponsored insurance programs[51]		86	82.8	91.3
% of children ages 3-6 years who have had the recommended number of well child visits in government sponsored insurance programs[52]		78.3	82.8	91.3
% of children ages 12-21 years who have had the recommended number of well child visits in government sponsored insurance programs[53]		59.5	61	67.1
% of children with any kind of health insurance - Ages 0-19 years[54]	(2010)	95.5 (94.6-96.4)	94.9 (94.5-95.3)	100
% of third-grade children with evidence of untreated tooth decay[55]	(2009-2011)	15.6 (11.3-19.8)	24.0 (22.6-25.4)	21.6
Ratio of low-income children to non-low income children[56]		4.58	2.46	2.21
Adolescent pregnancy rate per 1,000 females - Ages 15-17 years[57]	(2008-2010)	32.8	31.1	25.6
Ratio of Black non-Hispanics to White non-Hispanics[58]		6.55	5.74	4.9
Ratio of Hispanics to White non-Hispanics[59]		5.52	5.16	4.1
% of unintended pregnancy among live births[60]	(2011)	32.3	26.7	24.2
Ratio of Black non-Hispanics to White non-Hispanics[61]		2.63	2.09	1.88
Ratio of Hispanics to White non-Hispanics[62]		2	1.58	1.36
Ratio of Medicaid births to non-Medicaid births[63]		2.48	1.69	1.56
% of women with health coverage - Ages 18-64 years[64]	(2010)	90.5 (89.4-91.6)	86.1 (85.8-86.4)	100

Promote Mental Health and Prevention Substance Abuse				
Indicator	**Data Years**	**Monroe County**	**New York State**	**NYS 2017 Objective**
Age-adjusted % of adults with poor mental health for 14 or more days in the last month[66]	(2008-2009)	12.4 (8.9-15.9)	10.2 (8.7-11.7)	10.1
Age-adjusted % of adult binge drinking during the past month[67]	(2008-2009)	19.2 (14.4-23.9)	18.1 (16.1-20.2)	18.4
Age-adjusted suicide death rate per 100,000[68]	(2008-2010)	7.3	6.8	5.9

† Fewer than 10 events in the numerator, therefore the rate is unstable

Sources

[1]The number of deaths occurring before age 65 per 100 total deaths in the time period. (Vital Records, NYSDOH)

[2,3]The % of premature deaths before age 65 is calculated for Blacks, Hispanics and White non-Hispanics. The ratios are : Black non Hispanic/White non- Hispanic and Hispanic/White non-Hispanic (Vital Records, NYSDOH)

[4]The number of preventable hospitalizations per 10,000 population. The Prevention Quality Indicators (PQIs) are a set of measures developed by the federal Agency for Healthcare Research and Quality (AHRQ) for use in assessing the quality of outpatient care for "ambulatory care sensitive conditions" (ACSCs). This indicator is defined as the combination of the 12 PQIs that pertain to adults: short-term and long-term complications of diabetes, uncontrolled diabetes, lower-extremity amputation among patients with diabetes, hypertension, congestive heart failure, angina, chronic obstructive pulmonary disease, asthma, dehydration, bacterial pneumonia, urinary tract infection (SPARCS, NYSDOH)

[5,6]The rate of preventable hospitalization is calculated for Black, Hispanic and White non-Hispanics. The ratios are : Black non Hispanic/White non- Hispanic and Hispanic/White non-Hispanic (SPARCS, NYSDOH)

[7]The % of survey respondents (18 years and older) who reported that they had health insurance coverage. (2010 Current Population Survey , US Census Bureau CPS Table Creator.)

[8]The % of survey respondents (18 years and older) who reported that they had a regular health care provider. (BRFSS, NYSDOH)

[9]The number of hospitalizations (inpatient, ages 65 years and older) with primary diagnosis ICD-9CM external cause of injury codes E880-E888 (excluding E887) per 10,000 population ages 65 and older. (SPARCS, NYSDOH)

[10]The number of emergency department visits (ages 1-4 years) with primary diagnosis ICD-9CM external cause of injury codes E880-E888 (excluding E887) per 10,000 population ages 1 to 4 years

[11]The number of hospitalizations with primary diagnosis ICD-9CM external cause of injury codes E960-E968 per 10,000 population. (SPARCS, NYSDOH)

[12,13,14]The ratios are : Black non Hispanic/White non- Hispanic and Hispanic/White non-Hispanic and low-income zipcodes /non low income zip codes (SPARCS, NYSDOH)

[15]The number of emergency department visits (ages 15 to 19 years) with primary payer coded as workers' compensation per 10,000 population. (SPARCS, NYSDOH)

[16]Climate Smart Communities is a state-local partnership to reduce greenhouse gas emissions, save taxpayer dollars, and advance community goals for health and safety, economic vitality, energy independence and quality of life. (U.S. Environmental Protection Agency Air Quality System Data Mart http://www.epa.gov/ttn/airs/aqsdatamart/basic_info.htm)

[17]Alternate modes of transportation include public transportation, carpool, bike, walk, and telecommute. (American Community Survey)

[18]Low access is defined as greater than one mile from a supermarket or grocery store in urban areas or greater than ten miles from a supermarket or grocery store in rural areas (USDA Food Environment Atlas http://www.ers.usda.gov/data-products/food-environment-atlas/go-to-the-atlas.aspx)

[19]The NYS Healthy Neighborhoods Program provides in-home assessments and interventions for asthma, health hazards in high-risk communities throughout the state. During a visit an outreach worker provides education, referrals and products to help residents correct housing hazards. Homes can receive an optional revisit and reassessment. (Healthy Neighborhoods Tracking Sytem, , NYSDOH http://www.health.ny.gov/environmental/indoors/healthy_neighborhoods/)

[20]The Water Fluoridation Reporting System (WFRS) is an online tool that helps states manage the quality of their water fluoridation programs. WFRS information is also the basis for national surveillance reports that describe the % of the U.S. population on community water systems who receive optimally fluoridated drinking water.

[21]The % of survey respondents (18 years and older) who are obese. Obesity is defined as having a body mass index (BMI) of 30.0 or greater. BMI is calculated as weight in kilograms divided by the square of height in meters (w/h2). (BRFSS, , NYSDOH)

[22]The % of public school children who are obese. Obesity is defined as weight category greater than or equal to 95th percentile. Counties outside NYC: Grades K-12th; NYC counties: Grades K-8th (Student Weight Category Reporting System, , NYSDOH http://www.health.ny.gov/prevention/obesity/statistics_and_impact/student_weight_status_data.htm)

[23]The % of adults who report currently smoking cigarettes. (BRFSS, , NYSDOH)

[24]The % of survey respondents (ages 50-75 years) who received a colorectal cancer screening exam based on the most recent guidelines in the past year. (BRFSS, , NYSDOH)

[25]The number of emergency department visits with primary diagnosis ICD-9CM code 493.per 10,000 population (SPARCS, , NYSDOH)

[26]The number of emergency department visits with per 10,000 population ages 0-4 years. (SPARCS, , NYSDOH)

[27]The number of hospitalizations (inpatient) with a principal diagnosis ICD-9CM code 410 per 10,000 population. The rate is adjusted for age.(SPARCS, , NYSDOH)

[28]The number of hospitalizations (inpatient, ages 6-17 years) with a principal diagnosis ICD-9CM code: 25010, 25011, 25012, 25013, 25020, 25021, 25022, 25023, 25030, 25031, 25032, 25033 per 10,000 population ages 6-17 years. (SPARCS, , NYSDOH)

[29]The number of hospitalizations (inpatient, ages 18 years and older) with a principal diagnosis ICD-9CM code: 25010, 25011, 25012, 25013, 25020, 25021, 25022, 25023, 25030, 25031, 25032, 25033 per 10,000 population ages 18 years and older (SPARCS, , NYSDOH)

[30]The number of children (ages 19-35 months) per 100 population who received their 4:3:1:3:3:1:4 immunization series (4 DTaP, 3 polio, 1 MMR, 3 hep B, 3 Hib, 1 varicella, 4 PCV13). (NYS Immunization System , NYSDOH http://www.health.ny.gov/prevention/immunization/information_system/)

[31]The number of females (ages 13-17 years) per 100 population who received their 3-dose Human Papillomavirus (HPV) immunization vaccine. (NYS Immunization System, NYSDOH http://www.health.ny.gov/prevention/immunization/information_system/)

[32]The % of survey respondents (65+ years of age) who received their influenza immunization (flu shot) in the past year. The % is adjusted for age. (BRFSS, NYSDOH)

[33]The number of people newly diagnosed with human immunodeficiency virus (HIV), regardless of concurrent or subsequent AIDS diagnosis, per 100,000 population. Data are based on year of diagnosis and exclude prison inmates. (AIDS Case Surveillance Registry, NYSDOH)

[34]The new HIV case rate is calculated for both Black and White non-Hispanics. Then, the difference is the Black non-Hispanic rate minus the White non-Hispanic rate. (AIDS Case Surveillance Registry, NYSDOH)

[35]The new HIV case rate is calculated for Hispanics and White non-Hispanics. Then, the difference is the Hispanic rate minus the White non-Hispanic rate.(AIDS Case Surveillance Registry, NYSDOH)

[36]The number of women (ages 15-44 years) diagnosed with gonorrhea per 100,000 population (Sexually Transmitted Disease Surveillance System, NYSDOH)

[37]The number of men (ages 15-44 years) diagnosed with gonorrhea per 100,000 population. (Sexually Transmitted Disease Surveillance System, NYSDOH)

[38]The number of women (ages 15-44 years) diagnosed with Chlamydia per 100,000 population. (Sexually Transmitted Disease Surveillance System, NYSDOH)

[39]The number of men diagnosed with primary or secondary syphilis per 100,000 population. (Sexually Transmitted Disease Surveillance System, NYSDOH)

[40]The number of women diagnosed with primary or secondary syphilis per 100,000 population. (Sexually Transmitted Disease Surveillance System, NYSDOH)

[41]The number of infants born at less than 37 weeks gestation among infants with known gestational age. (Vital Records, NYSDOH)

[42,43,44]The ratios are : Black non Hispanic/White non- Hispanic and Hispanic/White non-Hispanic and Medicaid /non Medicaid (Vital Records, NYSDOH)

[45]The number of infants exclusively fed breast milk in the hospital divided by the number of infants with known breastfeeding status. (Vital Records, NYSDOH)

[46,47,48]The ratios are : Black non Hispanic/White non- Hispanic and Hispanic/White non-Hispanic and Medicaid /non Medicaid (Vital Records, NYSDOH)

[49]The number of deaths to women from any causes related to or aggravated by pregnancy or its management that occurred while pregnant or within 42 days of termination of pregnancy (ICD-10 codes O00-95, O98-O99, and A34 (obstetrical tetanus)) per 100,000 live births. (Vital Records, NYSDOH)

[50]The % of children ages 0-15 months, 3-6 years and 12-21 years in the Medicaid and Child Health Plus programs who have had the recommended number of well-child visits. (QARR http://www.health.ny.gov/health_care/managed_care/reports/quality_performance_improvement.htm#link2)

[51]The % of children, in the Medicaid and Child Health Plus programs, who had five or more well-child visits with a primary care provider in their first 15 months of life. (QARR http://www.health.ny.gov/health_care/managed_care/reports/quality_performance_improvement.htm#link2)

[52]The % of children between the ages of three and six years, in the Medicaid and Child Health Plus programs, who had one or more well-child visits with a primary care provider during the measurement year. (QARR http://www.health.ny.gov/health_care/managed_care/reports/quality_performance_improvement.htm#link2)

[53]The % of adolescents (ages 12-21 years), in the Medicaid and Child Health Plus programs, who had at least one comprehensive well-care visit with a primary care provider during the measurement year. (QARR http://www.health.ny.gov/health_care/managed_care/reports/quality_performance_improvement.htm#link2)

[54]The % of survey respondents (ages 0-19 years) with any kind of health insurance coverage in the past 12 months. (2010 Current Population Survey , US Census Bureau CPS Table Creator.)

[55]The % of third-grade children with evidence of untreated dental caries.

[56]The % of untreated tooth decay is calculated separately for low and non-low income children. Then, the ratio is the low income % divided by the non-low income %. (Oral Health Survey of 3rd Graders, NYSDOH)

[57]Pregnancies are the sum of the number of live births, induced terminations of pregnancies, and all fetal deaths. Pregnancy rates are the number of pregnancies per 1,000 females ages 15-17 years. (Vital Records, NYSDOH)

[58,59]The ratios are : Black non Hispanic/White non- Hispanic and Hispanic/White non-Hispanic (Vital Records, NYSDOH)

[60]The number of unintended pregnancies (current pregnancy indicated as 'Wanted Later' or 'Wanted Never') among live births with known pregnancy intendedness. (Vital Records, NYSDOH)

[61,62,63]The ratios are : Black non Hispanic/White non- Hispanic and Hispanic/White non-Hispanic and Medicaid /non Medicaid (Vital Records, NYSDOH)

[64]The % of survey respondents (females, 18-64 years of age) who reported that they had health insurance coverage

[65]The number of live births that occur within 24 months of a previous pregnancy among all live births.

[66]The % of survey respondents (ages 18 years and older) who reported experiencing poor mental health for 14 or more days in the last month. The % is adjusted for age (2010 Current Population Survey , US Census Bureau CPS Table Creator.)

[67]The % of respondents (ages 18 years and older) reporting binge drinking on one or more occasions in the past 30 days. Binge drinking is defined as men having 5 or more drinks or women having 4 or more drinks on one occasion. The % is adjusted for age. (BRFSS, NYSDOH)

[68]The number of deaths with an ICD-10 primary cause of death code: X60-X84 or Y87.0 per 100,000 population. The rate is adjusted for age. (Vital Records, NYSDOH)

APPENDIX B